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Standing Committee on Finance and Economic Affairs

Comité permanent des finances et des affaires économiques

Pre-budget consultations

Consultations prébudgétaires

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41st Parliament

Friday 19 January 2018

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Vendredi 19 janvier 2018

Chair: Ann Hoggarth
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Friday 19 January 2018

Vendredi 19 janvier 2018

The committee met at 0904 in St. Clair College Centre for the Arts, Windsor.

PRE-BUDGET CONSULTATIONS

The Chair (Ms. Ann Hoggarth): Good morning. We are meeting here in Windsor today to hold pre-budget consultations. As this is an extension of the Legislature, there can be no clapping, cheering, signs or political material in the room.

Each witness will receive up to 10 minutes for their presentation, followed by five minutes of questioning from the committee.

Are there any questions before we begin? Yes, Mr. Hatfield.

Mr. Percy Hatfield: Thank you, Madam Chair. My question: During those five minutes of questioning by the committee, if you could explain to the audience how that rotates so they don't think we're ignoring them or anything.

The Chair (Ms. Ann Hoggarth): Okay. What happens is there is a rotation. Each party gets five minutes but not with every presenter. The opening group that will ask questions is the government today. At the end of the last day, it was the third party, so then it's the government's turn to start today. Then the next presenter will be questioned by the official opposition, and the next one by the third party. So not every party questions every presenter.

Mr. Percy Hatfield: Thank you. They get the full five minutes.

The Chair (Ms. Ann Hoggarth): Yes, they do.

Any further questions? Seeing none, we will move to the first presenter.

WINDSOR AND DISTRICT LABOUR COUNCIL

The Chair (Ms. Ann Hoggarth): I will call upon the Windsor and District Labour Council. Good morning.

Mr. Brian Hogan: Hi. How are you today?

The Chair (Ms. Ann Hoggarth): Good. Once you get settled, if you could please identify yourself for the purpose of Hansard, and then you may begin your 10 minutes.

Mr. Brian Hogan: Good morning. I'm Brian Hogan. My colleague Shelley Smith is from the health care sector; she'll take care of that part. I'm going to focus on a variety of issues that help the neediest Ontarians.

I appreciate the good start with Bill 148; however, now in Ontario, we're seeing how the lack of some changes to the laws is affecting workers. Tim Hortons is one example of an employer treating workers unfairly; it's not the spirit of the law. Workers need greater protections, a voice and a union. Ontario's labour laws fail to make real access to unionization and collective bargaining a reality for many workers, particularly for ones in franchises. The only way to bargain effectively and to improve employment conditions for workers is to bargain collectively with multiple locations of Tim Hortons. Even the special advisers for the Changing Workplaces Review agree, but the law doesn't allow for this.

Further, another issue: The law also doesn't recognize that when workers vote to join a union, their vote should count. Most workers are forced to vote a second time. As you know, employers hold the balance of power. When they try to get a first contract, if you will, that's obviously a problem. All Ontarians have the constitutional right to unionize. The government must make it easier to join a union and extend card-based certification to all sectors.

The next issue: poverty and income security. Do you know Windsor leads the country in child poverty? We encourage the government to fully implement the recommendations contained in the Income Security: A Roadmap for Change report. It's a good report; let's implement it.

I will add that there is a need to extend public dental programs for children to include low-income adults and seniors.

Another marginalized group in Ontario is citizens with developmental disabilities. Their services are from agencies, like Community Living, that do great work. These agencies have not had a funding increase for nine-plus years. This obviously affects the services to the clients. It also affects the workers with issues such as Bill 148 and pay equity. I don't know if you know that there is a wait-list of approximately 20,000 for supportive housing.

The next issue is addictions. I'm sure you've heard this across the province: There's a need for support to organizations dealing with the effects of the opioid and substance abuse epidemic, including harm reduction programs and outreach workers.

Pharmacare: When there's an increase in insecure work, fewer Ontarians have access. You're on the right track. Continue to be the leader. Let's get it across to more than just youth.

Housing: Ontario has one of the largest social housing wait-lists in the country. Windsor is no exception. Our citizens need it and certainly our local government cannot do it alone. Ontario needs a comprehensive social housing program that treats housing as a public utility and delivers it according to need.

Privatization of public services: This is a list. As I said, I'm talking about the neediest. Prioritize the interests of the collective and the vulnerable. Don't sell off our public services.

Education in the elementary sector: There is an increase in and a growing concern about violence. Put in some funding for more training of staff to report procedures for these violent activities.

For a meaningful difference to children and their families, focus on more funding for mental health and focus on more funding for special education. Again, they're our neediest.

0910

The catch-all, as you know—you've heard it from all kinds of groups—is that if you invest in universal, accessible, regulated and publicly funded child care, that helps everybody. It helps poverty decrease.

You probably know that the way to help women gain economic justice is to improve government services such as child care.

Lastly, college: A focus of Bill 148 was to help precarious work. Do you know of another employer that has 70% part-time workers? You had an opportunity and you didn't meet the mark—70% part-time workers. You allowed management to try to break the union, and all it did was affect students for five weeks.

Did you know that funding in Ontario is one of the lowest in the country?

Thanks. Go ahead, Shelley.

Ms. Shelley Smith: Hello. My name is Shelley Smith. I'm a trustee on the Windsor and District Labour Council, a trustee of the executive board of my local and a health care worker of 32 years in a long-term-care facility.

I've come here today hoping to give you a greater understanding of the importance of the Premier's announcement of Aging with Confidence: Ontario's Action Plan for Seniors, which allows for a minimum standard of four hours of direct care for our residents, and the need to fund and implement the changes immediately.

Workers in long-term care at times are the family to our residents. One little story that I'd like to give you is about a gentleman who, when he passed away, had no family. At the time he knew he had a sister, but his sister didn't live in the city. He used to receive a Christmas card every year from his sister. The Christmas cards had stopped coming approximately two or three years prior. He would say to me, "Shelley, I didn't receive a Christmas card from my sister this year." So, in turn, I would give him a Christmas card in place of the sister.

We didn't know what happened to the sister. We thought perhaps she ended up in a long-term-care facility herself or she had passed away, and to this very day we still don't know what happened to her.

He passed away. He was a close resident to me. The day he passed away, I wasn't at work. I received several calls saying that he passed away, so I went to the workplace and he had passed away, but he had nobody to prepare anything for him. He had the home, which deals with specific issues, but he didn't have a suit to wear, he didn't have anybody to attend his funeral. So myself and my niece attended his funeral.

The Chair (Ms. Ann Hoggarth): Can you please turn the mike slightly?

Ms. Shelley Smith: I'm sorry.

The Chair (Ms. Ann Hoggarth): Thank you. These mikes are very strong.

Ms. Shelley Smith: In order to have someone at his funeral, my niece and I attended his funeral.

When we were at the funeral parlour, the funeral director said, "Well, will anyone be going to the gravesite?" I don't know why it didn't hit me that we needed to go to the gravesite, but my niece and I followed the hearse to the gravesite. There was no one there to give him a prayer before he was laid to rest. The funeral director did know of somebody there. That person just happened to be a man of the cloth, so he came and said a few words before lowering him into the ground. Then we realized that he had no flowers. He had nothing on his grave but dirt, so we left to go and purchase a small bouquet to come back and put on his grave.

Some may say that's not our role, but it is our role. We're health care providers. We don't just provide a service to them and not have any feelings. They are a family to us.

With that being said, health care is in a crisis. The violence that is in health care—violence to residents, violence to workers—is on an increase. We all know it's on an increase, because we hear of the stories that are reported in the news about this. Unfortunately, these stories are reported but nothing has changed from these events. Some people have died because of these events, and there still have been no serious changes to long-term care.

There was a young girl who was doing her job. She was walking down the hall past the room of one of the residents, and this resident did have some violent tendencies and some behaviours. He was a minute from a mental institution—or he had some mental issues; I shouldn't say that he was a minute from a mental institution.

He had no trigger. Sometimes there's a trigger. You know what will set off a resident and what will make them angry. But this man was totally unpredictable, and he also had a black belt in martial arts. The fear was great for workers, for residents, for everyone who lived in long-term care and worked in it because, as I said, there was no trigger for this gentleman.

At times, he would wander into residents' rooms, and the intervention that was put in place was that if he was

to go into a resident's room, we were to go in and remove the resident from the room, because if that resident had said something to him, we don't know what would have transpired. But even with that being said, we don't have enough arms, legs, bodies or time to give the care that we need to the residents and to monitor these situations that go on.

Health care workers in long-term-care homes are also feeling stressed out, discouraged, outraged and fearful: discouraged because no one hears their concerns; outraged because the mentality in the community is that we are at fault for some of the stories reported; fearful of the residents whom we care for, and fearful of the disciplinary action that follows my inability to complete a task for a resident. This is a direct result of understaffing, lack of time, an increase in—

The Chair (Ms. Ann Hoggarth): Thank you. We will move to the government. MPP Colle.

Mr. Mike Colle: Good morning and thank you both, Brian and Shelley. You certainly brought another dimension to these budget hearings, and that is the human side of it and the passion that a lot of front-line workers like yourself show. I really think that's something that the general public sometimes forgets and we, as elected officials, need to be reminded of.

It just made me think, when you were talking about your loving care for the gentleman who passed away: In England, they had the Cox commission. They just completed the Cox commission. It was in memory of Jo Cox, the MP who was gunned down in England a couple of years ago. In England, they've just appointed a minister in charge of loneliness to address that very issue of ensuring that their seniors get more attention and care. It goes beyond emotional supports. It goes towards actual government intervention in ensuring that seniors are not left all by themselves without anybody to help.

Just as a follow-up to what you said, it reminded me of that. Maybe that's something that we, as members of the Legislature, have to look at in the future: What impact does being alone and abandoned have on people's health and the ability of front-line workers to deliver good services? That's something that's worthwhile to look at.

I just want to mention—I think you mentioned it too—the new action plan for seniors where we're going to increase the number of hours of care from three to four and we're trying to pay more attention to the needs in long-term care. Can you just explain about the challenges you have in long-term care and taking proper care of people?

Ms. Shelley Smith: Well, the challenge is bodies and the challenge is time. When you go in in the morning to get a resident up, you have two full-time staff and a half shift, a 6-to-10. We have 35 residents we have to get up. Their breakfast is at 7:30. So we have that time to get them up, toileted, showered, dressed in a choice of clothes that they would like to wear, hair combed, teeth brushed. And all of that has to be done—and some of them are mechanical lifts—total care. The majority of them are; there's very few who are independent. The problem is that you have to do that without rushing them, because rushing them can cause increased behaviours. So the time is rushed.

The time is rushed, and the bodies are not there to assist. When you're trying to provide care and you have residents who have behaviours and are wandering in and out of everyone's rooms, you may be at one end of the hall. If a resident is wandering into another resident's room, you're not going to hear what's going on down there, because you're trying to prepare the residents and get them ready for breakfast to go to the dining room.

0920

I feel that the biggest challenges in my job are the time to do it properly and give them care in a respectful, timely, dignified manner, and that I don't have enough bodies to help me do it.

Mr. Mike Colle: It's basically enough bodies, really, more trained professionals on the floor.

Ms. Shelley Smith: More trained professionals, but for myself I even feel that sometimes I'm not qualified to care for those who have mental challenges. They require a lot of time, if they have behaviours, and they require a lot of monitoring, because they do roam into other residents' rooms, they are violent, and sometimes if they lash out at that resident in the room because you're not there at that time, the outcome can be horrific. But the outcome is not because I'm not doing my job; I just don't have the time and enough bodies to do it properly.

Mr. Mike Colle: Yes, especially with the challenges. Thank you.

Just to get back to you, Brian, as you know, across Canada today workers are manifesting their displeasure with one Brazilian company that has a coffee monopoly in Canada of sorts that is trying to block workers from getting their rights under Bill 148—I know there's one in Windsor. Right across Canada, there are organized attempts to try to say that what some companies are doing is wrong in denying workers their benefits and rights. I don't know if the district labour council is involved in this; I think there's an event here in Windsor at 11 o'clock.

Mr. Brian Hogan: Yes, just down the street. As I said, Bill 148, lots of good things there and—

The Chair (Ms. Ann Hoggarth): Thank you for your presentation. If you have a written submission, it needs to be to the Clerk by the end of today at 5 o'clock. Thank you.

Mr. Brian Hogan: It's always a pleasure. Thank you very much for your time.

Ms. Shelley Smith: Thank you so much.

LEGAL ASSISTANCE OF WINDSOR

COMMUNITY LEGAL AID

The Chair (Ms. Ann Hoggarth): Calling our next presenters: Legal Assistance of Windsor and Community Legal Aid. Good morning. Once you get yourself

situated, if you could state your names for the purposes of Hansard, and you may begin your 10 minutes.

Ms. Marion Overholt: Thank you. I'd like to welcome the committee to Windsor. I'm delighted to have the opportunity to present to you today. My name is Marion Overholt. I'm the executive director of Legal Assistance of Windsor and Community Legal Aid. These two clinics are low-income poverty law clinics serving Windsor and Essex county. With me is Lilian Bahgat, who is a staff lawyer at Community Legal Aid. I will be speaking about income security, and Lilian will be talking about employment standards.

I have been at the clinic of Legal Assistance of Windsor for nearly 30 years, and every time this committee has come to Windsor, I have made a presentation. I always talk to you about poverty, and I'm talking to you about poverty today.

One of the things I wanted to talk to you about was the report, Income Security: A Roadmap for Change. I just wonder if the members of the committee can raise their hands if they've actually read the report. Thank you. I see that both Ms. Gretzky and Mr. Hatfield have read the report.

Part of what happens when we talk about income security and poverty is it's difficult for people to really understand what a devastating situation this is. Every time I come to the committee, I tell you that there is a very simple solution, and that is that you must stop legislating poverty, because that's what you're doing when you set the rates of social assistance well below what it costs a person to be able to feed, shelter, live and have transportation on a day-to-day basis.

You heard from Mr. Hogan about the lack of social housing in Windsor. I want you to know that at the present time, the waiting list for social housing exceeds the number of rental units available in social housing. That means if everyone who has a social housing unit moved out tomorrow, there are still going to be people on that waiting list.

I've just had the experience in our clinical work of working with somebody for the last six months who has been homeless. The amount of time and the cost to that individual both in terms of mental and physical frailties that have resulted from him being homeless over that period of time, never mind the expense of the agencies working with him and the police—it's shameful in a country like Canada that we have this situation happening on a daily basis.

All of you know from your own communities there has been a shelter crisis because of the severe weather that we've experienced. I'm here today to tell you it's fixable and what you need to do is address the recommendations that are in Income Security: A Roadmap for Change. That report has a 10-year reform program. It's laid out. It would help both low-income workers and people receiving social assistance.

Our existing system is inadequate, punitive and coercive. It's inadequate because the benefits and services do not address the needs of the clients. It's punitive in that it punishes people when ordinary life events occur, triggering both a financial and personal crisis. And it's coercive because it forces clients into rigid stereotypes and benefit structures that don't meet their needs. As a result, our clients experience more isolation and income insecurity, and they find it much more challenging to participate in employment.

The road map has the endorsement and input of municipal and provincial managers, people with lived experience, social policy experts, advocates for low-income people, the private sector, the Chiefs of Ontario and a range of First Nations communities. The public feedback has been positive. Therefore, it's time to act.

We congratulate the government for initiating the basic-income project that is under way in select communities, and we are anxious to see the long-term results of that initiative. But in the meantime, it is imperative for the government to act and relieve the plight of social assistance recipients across the province.

There are two recommendations I would like to focus on.

First is the recommendation to simplify the rate structure in social assistance. The recommendation would collapse the "basic needs" and "shelter" portions of benefits and eliminate the other rate categories.

There are three goals addressed in that recommendation:

(1) To reduce intrusion into clients' lives.

(2) The current distinction creates an artificial distinction where no one can live on the "shelter" portion of the cheque. Clients regularly allocate the "basic needs" portion of their money towards rent and heat, and most recipients are spending more than 50% of their social assistance on shelter. Meanwhile, those clients who are homeless are expected to live month to month on the "basic needs" portion, which is totally inadequate and only exacerbates their housing crisis.

(3) The flat rate would also allow social housing recipients to receive more money each month, and it would flow more money to social housing and provide funds to address the necessary maintenance repairs. If you look at the city of Windsor budget, it's woefully inadequate what the city is able to allocate toward maintaining those units. As those units hit a point of disrepair, they are taken out of service, and it compromises the number of units available.

The second issue is requesting a rate increase. The road map recommends a 10% increase to Ontario Works clients and a 5% increase to ODSP. This is the very least that the government can do to address the loss of purchasing power imposed by the 21.6% cut in the 1990s and the eight years of rate freezes that have followed.

In this brutal winter, we have seen the fallout of the failure of previous governments to intervene with the provision of adequate benefits. The extraordinary income insecurity created by the existing system has created more homelessness, addiction and housing crises. As a community, we incur higher health costs. Our social cohesion and sense of community is strained when citizens

see, day after day, that they are not valued or cared for by their government.

As a province, we can do better. We need to stem the economic costs that are caused by the loss of productivity. This is your opportunity to make an investment in the citizens of the province of Ontario.

Ms. Lilian Bahgat: Good morning. I'm grateful for the opportunity to return and speak to this committee about Bill 148.

Back in July when we came before this committee, our primary concern was the enforcement of law. Now that the bill has become law, it is more important than ever to ensure that the employers properly understand their new responsibilities.

As previously mentioned this morning, as I sit here and speak with you, there are dozens of organized events taking place around our province to show support for these minimum wage workers, part-time workers who have had to suffer "offensive" measures, we will call them, taken on by their employers. We described to the committee back in July some of the cases, which included the common theme of a lack of enforceability of the Employment Standards Act.

0930

We're encouraged by the minister's January 15 press release speaking about the measures that are going to be put in place. Our recommendation is that the funding for these measures be expedited in this budget so that it has a meaningful effect on workers' rights.

A legal right is not fully appreciated until it receives protection, which only comes through enforcement. Workers should not be given a hollow right that can be easily violated by their employer, with no remedy in place. They should not be asked to wait several years to have their enforcement rights. Let's not kick the can down the road and just wait for someone else to effectively fund enforcement measures.

The efficacy of the new protections will not be fully realized by Ontario workers until the government ensures that the enforcement branch of the ESA is strengthened. Without proper resources for enforcement, non-compliant employers will continue to factor in ESA violations as an ordinary cost of business.

The most vulnerable of our society historically have borne the brunt of the flagrant behavior of those far more empowered than them. Their basic employment rights should not be violated as a result of a lack of resources.

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Lilian Bahgat: Thank you. What I want to basically say is that Bill 148, whether you like it or not, has become law, and we have to enforce these laws. We've begun to see—and there are public conversations about—how employers have chosen to offset the effect of Bill 148, and it really falls on the backs of low-wage employees.

We're looking for proper and effective funding of these enforcements. This is the way we support all our communities. Whichever side you sit on in this debate, at the end of the day, you support your communities by ensuring that those who are not violating the law are not being outcompeted by those who flagrantly choose to violate the law. Let's please put in effective measures to enforce this law. Thank you.

The Chair (Ms. Ann Hoggarth): Thank you. We'll move to the official opposition, MPP Barrett.

Mr. Toby Barrett: Thanks for the presentations on social assistance prevalence and also on the minimum wage. You started off talking about pressure on housing. I don't know whether you have a handout or not. How many homeless are there in the area in a percentage, or numbers?

Ms. Marion Overholt: They tried to do a count last summer to get an approximate number, but what has happened with this cold spell is that the local shelters are full, so we've had agencies that are not typically funded to be a shelter try to provide shelter because there have been so many people seeking assistance.

It was interesting. Our office is a two-block distance from this hearing today. On the way here, we encountered a number of people clearly going to the downtown mission after spending a night in the rough. It's a huge concern, and if you pick up any paper in Ontario, you're going to see the issue of homelessness on the front page. It needs to be addressed.

I think if you look at the report, Income Security: A Roadmap for Change, they're asking for a housing benefit to be specifically funded through that program, and one that's portable, so that as you move from community to community, your housing benefit can go with you. The way the current system is set up, it is so regulated and so specific, whether to a community or to particular housing, that we have people who maybe will qualify for a housing benefit, but because of an opportunity to take a job, they can't take it because their housing benefit isn't going to follow them, and given the rate of pay they're going to receive, they're not going to be better off.

Those comprehensive changes are really critical.

Mr. Toby Barrett: Just a number: How many beds would there be available? As you say, not enough, but—

Ms. Marion Overholt: No. Part of what happens is when there's an overflow, they end up putting people up in hotels. So I think locally we're looking at about maybe 300 beds? But I know people are regularly put up in a hotel because there isn't a shelter for families, and our domestic violence shelter regularly turns away women because they are at capacity. In this whole area of housing, partly what has happened here is really a 30-year decline in government commitment, on both the federal and provincial levels. It needs to be rectified because every community has the kind of aging social housing that we have, and we're not seeing that impetus to create new housing. That's just going to exacerbate the crisis.

Mr. Toby Barrett: The Ontario Works figures: Are those turning around at all, or are those just continuing to grow? I'm not from Windsor. I own several vehicles that were actually built in Windsor.

Ms. Marion Overholt: Good for you; it's important to support the local economy.

Mr. Toby Barrett: Are we turning the corner at all on this?

Ms. Marion Overholt: You mean in terms of people needing social assistance?

Mr. Toby Barrett: The bottom line is to get people back working, the people you're talking about.

Ms. Marion Overholt: Yes. See, what happens is that we've seen our rates of social assistance, the number of people on social assistance, stabilize, but what we experience is this cycle where maybe they'll get off and then start working, but given their housing situation, they're encountering some kind of crisis and they may end up back on. So people will cycle back onto social assistance. With this increase in minimum wage, we're hopeful that some people are going to be lifted out of poverty because their wages have increased. But that housing piece absolutely has to be addressed, and that's part of income security.

Mr. Toby Barrett: And are we seeing the layoffs in this area because of the minimum wage?

Ms. Lilian Bahgat: We're seeing a lot of creative ways to effectively ensure the employees bear the burden of the bill. We're seeing a lot of cutbacks; we're seeing a lot of benefits being taken away, breaks being taken away, that sort of thing. And definitely there are layoffs that have taken place, yes.

Mr. Toby Barrett: Thank you.

The Chair (Ms. Ann Hoggarth): Thank you for your presentation. If you have a written submission, it needs to be to the Clerk by 5 o'clock tonight.

HÔTEL-DIEU GRACE HEALTHCARE

The Chair (Ms. Ann Hoggarth): I call the next presenter: Hôtel-Dieu Grace Healthcare. Good morning.

Dr. Mary Broga: Good morning, and a warm welcome to Windsor-Essex. It's one of the few days we can say "warm." We're not having bone-chilling weather.

The Chair (Ms. Ann Hoggarth): Thank you very much. If you would identify yourself for the purpose of Hansard, you may begin your 10-minute presentation.

Dr. Mary Broga: My name is Dr. Mary Broga. I'm a clinical psychologist by profession. I'm here to represent Hôtel-Dieu Grace Healthcare in my capacity as executive director, lead agency for children and youth mental health of Windsor-Essex. Also with me is Karen Wilson, who is our family engagement consultant.

Over the past several years, child and youth mental health has become a growing concern for families, educators, society in general and youth themselves. Stigma is slowly decreasing, and for that we are grateful, but it's not decreasing fast enough. Families and youth are still reaching out for mental health supports.

The number of our young people affected is significant, with a provincial figure of one in four youth in Ontario suffering from a significant mental health issue each year. Without treatment, they are at further risk of developing social and vocational problems, as well as addictions.

Yet we know treatment works. A 2010 RAND Corp. literature review of proven early childhood interventions in mental health found a return on investment of $1.80 to $17.07 for every dollar spent on mental health programming. According to the Mental Health Commission of Canada, improving a child's mental health from moderate to high can lead to a lifetime savings of $140,000.

This provincial picture plays itself out in Windsor-Essex, with its child population of about 88,000. Our region is also the fourth most diverse community in the country, with added need for mental health supports for newcomers. However, wait-lists are a significant barrier to timely access to needed services. Wait-lists are a significant and chronic issue and illustrate graphically our Windsor-Essex local crisis in system capacity.

In Windsor-Essex, we receive about $16 million from the Ministry of Children and Youth Services to support children and youth with mental health issues and their families. With this amount, we have created a mental health system that can respond to the needs of children and youth from birth all the way to 18 and their families by offering the core mental health services as defined by the ministry.

I am very proud to be a part of our community of providers. We have a long history of working collaboratively together to meet the needs of children, youth and their families. In the past we actually had about 12 organizations offering services to this population, but we have restructured ourselves into four core mental health providers, because we fundamentally believe it is about our children and families and not about organizations.

0940

We have an efficient infrastructure in place, with well-trained staff delivering evidence-supported interventions. We are in a position to work with other sectors and ministries in partnership to ensure our children and families remain our promise to the future, but wait-lists remain the issue. We have built the system of services, but the depth is not there to support the need. Our crisis is in system capacity to meet the needs of our children and youth.

For example, at Maryvale Adolescent and Family Services, the six hospital beds serve 270 or more children and teens each year, the majority of whom need follow-up mental health support. There are another 69 waiting five months for counselling and another 23 waiting for day treatment.

At Children First, which supports children from birth until age six and their families, the average wait is about four months from initial referral to intervention. For such young children developmentally, this is a significant amount of time, because so much growth is occurring at this critical period. Typically there are about 100 young children waiting for various mental health services at this agency.

At Regional Children's Centre there are 520 children waiting for mental health services, with 240 of those waiting for counselling and therapy. They can expect to wait for over three months.

We are ready to receive funding that can immediately be put into serving our child population. With $3 million, we could address current pressures by providing counselling to teens to keep them safe and attending school, both in the city and in the county, and providing services for children waiting at Children's First and the Regional Children's Centre.

I need to say that our community would not be shovel-ready if it were not for our partnership with parents and families. As mental health providers, we have come to appreciate the importance that families play in helping us understand what services are needed and how they should be delivered to be person- and family-centred. I'm going to pass it to Karen.

Ms. Karen Wilson: Good morning. My name is Karen Wilson. I'm a teacher by profession and currently work as an academic disability adviser. I have been a volunteer children and youth mental health advocate for over 20 years. I have a 22-year-old son with severe mental health and behavioural challenges and a 20-year-old son with high-functioning autism.

I consider myself one of the lucky ones. Despite there being at least six agencies we had to navigate along our journey to get help for our oldest son, there was help available. In fact, his needs were so challenging he needed to live residentially since the age of 12. This community had the resources, the programming and the capacity to give him the intensive treatment he needed. They saved his life, my husband's and my mental and physical health, and they kept our son out of jail.

The care and education he received from our treatment agencies throughout all those years kept him safe and taught him how to channel his anger, change his behaviour and turn his emotional dysregulation to measured control. They taught him strategies that allow him to lead an integrated life and, today, to be a contributing member of our community.

The classroom and residential placement programs that Robert benefited from are now closed. The families today with a child like mine are left jobless, as they must quit to take full-time care of their child. The schools have suspended them for brain-based behaviours beyond the child's control. There is no longer any long-term cognitive behavioural therapy that my son received. It has been replaced with short group treatment programs or brief interventions. The wait-list for day treatment is measured in months or years or simply eliminated, because there's no hope in sight for new admissions.

My son is now in adult services, living residentially in his own ensuite apartment, which has a full-time, one-to-one staff. When this happened, we felt like we won the lottery, but the unmanageable and hellish life we lived for the previous 19 years came at the expense of my 22-year marriage. We had what seemed to be a thousand appointments, the trips down the highway to CPRI when he was an in-patient and had to fight the system to get his necessary treatment without having to give him to the CAS.

Sandra Pupatello, the minister of MCYS at that time, made a provincial announcement that no parent would have to surrender their child to the CAS to receive mental health care in reaction to my story and others. It was at that point I vowed to make this a better system for all families that came after me.

I fear I'm failing miserably. When families used to come to my support group for help, I was always able to guide them in the right direction for treatment their child and family needed. Now when I hear their stories and their desperate pleas for my help, my heart breaks. I take a deep breath, and I give them the bad news. I find myself in meetings with CAS workers and families, trying to support a family while a stranger arranges a temporary custody agreement to send their child out of town to get the necessary treatment. Or worse. I help research private treatment facilities four hours away that claim to offer what our children and youth need. It feels terrible and it's heartbreaking. I cannot imagine, when we were in crisis, there not being a viable solution right here in Windsor.

I have been honoured to be the family engagement consultant for our lead agency for the past two years. I work closely with all four children's mental health treatment agencies and helped each of them to establish their own family engagement groups. The families are meeting regularly to better their family experience when going through the system.

Our agencies do work well together and are doing their absolute best to meet the growing demand. I have sat in meetings with the executive directors over the past few years when with tears in their eyes they have told me about another program they need to close down because of lack of funding. It breaks their heart, it breaks families, and it breaks this community.

Agencies have shortened treatment programs from 16 weeks to eight weeks to shorten the wait-lists and allow more children and youth timely service, but we all know that is not the solution. They run programs once a year rather than quarterly out of necessity.

As a parent and a consumer of these services, I know the dangers of delaying treatment while children and youth languish on wait-lists. When my then-seven-year-old son told me he didn't want to wake up tomorrow and was crying all the time, I walked into RCC and he saw a psychiatrist that day. He continued receiving help immediately, and long-term help, because it was imperative—

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Karen Wilson: —we helped him when he wanted to die. He got what he needed when he needed it, and today, 13 years later, he attends St. Clair College and is an aspiring mechanic.

Today, families bring their children into the emergency or walk-in clinic and then the waiting begins. They are prioritized by level of need and shuffled to the appropriate wait-list for service. The families are desperate for help, support and knowledge to bridge the time when they are the only support and help for their child. Most are completely at a loss how to do this. Some parents are on 24/7 suicide watch over their children as young as five years old, not knowing what else to do while they wait.

We need timely services. Shortening wait-lists is not enough; we need to eliminate them. Our agencies are ready to move to this next level of immediate service for every child and youth. They know what to do and they know what our children and youth need. What they need is the funding to rebuild their capacities and resources. I know they will hit the ground running. Do not let any more of our kids get sent away or develop more mental health problems while they wait. Fund this community sufficiently to allow equitable and timely access for every child and youth in need.

The Chair (Ms. Ann Hoggarth): Thank you. We'll go to the third party. MPP Gretzky.

Mrs. Lisa Gretzky: I want to thank you for your presentation. Just to drive the point home here about the need for mental health services and supports down here in Windsor, I'm going to share a couple of stories.

I have a very good friend—both mothers are teachers. Their daughter, just shy of a year ago, at 19 years old, died by suicide. Their two younger daughters were told it would take six to eight months before they could see a grief counsellor—six to eight months. The two moms were told it would be closer to two years.

I recently stood in the Legislature and talked about Ida Harry, whose 12-year-old son has tried to take his own life several times. They're in the cycle of going to the emergency department, where they are often seen by a medical student or a counsellor and shuffled back out the door because the hospitals don't have the resources to help him. Then often, that turns into an encounter with our local police force.

I have a grandmother who has come forward, whose 12-year-old grandson, again, has tried to take his own life several times. He also has a developmental disability. She has been told that for that grandson, who needs the stability of being with his grandmother, the only treatment that he could get that might help is if she shuffles him off down the road to London without her so that he can get the support he needs at CPRI.

That being said, I wonder if you could talk about the capacity that we actually have here in Windsor. Please talk about the infrastructure that we have in place and the skilled people that we'd have here in Windsor if there was actually operational funding in order for you to be able to provide the services to the people here—and it's not just Windsor; it's across the province—if they were actually given the funding that they needed.

Dr. Mary Broga: Sadly, your stories are just too common right across the province. I have to say, for child and youth mental health, it's been a long and slow erosion over the last, I would say, 15 years. Funding has not kept up with inflation. In fact, we are discretionarily funded, not mandatorily, which means that it's whatever is left at the end of the day.

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What we've done as a community is look at the core services to make sure that we have that bandwidth to meet needs. But as I was saying, the depth is so shallow that that creates the waiting list. That's been the way it's been built over the years, not being able to meet the need. One in four kids has significant mental health issues. Five out of six don't get the service they need. That tells you what the gap is. We're just treading water at the moment.

I think what our communities are doing is trying any means possible, with whatever resources that they still have in place, to bring them out and maximize them to the fullest. But it's not meeting the need. It's not meeting the absolute need. And because stigma is going down, families are much more aware of mental health issues; schools are talking about it. We also know there are more kids out there that want service. So what is the real need? It's the five out of six in our child population that aren't getting the service now, and that's right across the province.

The $3 million I referenced—that's just to take care of the waiting list that we have, in the way that we're doing it now, which is kind of short-term, not in the in-depth way we really need to attend to kids' problems.

Mrs. Lisa Gretzky: Right. Now, my colleagues and I have had the opportunity to tour Hôtel-Dieu Grace hospital and look at the facilities there. My understanding—and you may not know the numbers; if you do, please correct me—is that there are currently 89 beds, turnkey, ready to open—they are there—that could service people in our community, with a potential 119 beds should there be operational funding.

Dr. Mary Broga: Correct.

Mrs. Lisa Gretzky: So that's providing funding to actually have the staff there to provide service.

The Chair (Ms. Ann Hoggarth): One minute.

Dr. Mary Broga: We need the operational dollars.

Mrs. Lisa Gretzky: Okay. And then I'd like to just touch on the developmental services. Do you find that the government's new approach to autism services—how is that affecting families in Windsor? Is that making a big change for them?

Dr. Mary Broga: I wouldn't say it's making a big change. Again, our families are given money directly so they can buy their own services. Unfortunately, in many communities, there's no one to purchase from. The services just don't exist.

Karen, you may want to speak a little—you know those families better than I.

Ms. Karen Wilson: Well, I think what's happening to a lot of them is that they're being excluded from school, and the hours that they get from the ministry that allows them to hire a worker simply aren't enough and the families are still having to quit their jobs to take full-time care of these children who have been excluded from school as well.

The treatment program for someone with autism is not a short mental-health, brief counselling, brief intervention treatment. It's zero and lifetime mental health intervention for many, many of these children and youth with autism, and it continues well into their adult years. It's extremely cost-heavy—

The Chair (Ms. Ann Hoggarth): Thank you for your presentation. If you have a written submission that you'd

like to present, it needs to be to the Clerk by 5 o'clock tonight. Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION, WINDSOR-ESSEX COUNTY

The Chair (Ms. Ann Hoggarth): I call our next presenters: the Canadian Mental Health Association, Windsor-Essex County. Good morning. When you're ready, if you could identify yourself for the purpose of Hansard, and you may begin your 10-minute presentation.

Ms. Claudia den Boer: Thank you very much and good morning. My name is Claudia den Boer and I'm the CEO of the Canadian Mental Health Association, Windsor-Essex County branch. We have 30 branches of the Canadian Mental Health Association across the province and approximately 3,900 staff that provide front-line mental health and addiction services to tens of thousands of Ontarians across the province. As you likely know, the branches are funded primarily by the Ministry of Health and Long-Term Care, with additional project-based funding for specific programs.

I have three key asks related to mental health and addiction funding. The first is to invest locally to support Ontarians where they live. In alignment with the submission from Canadian Mental Health Association, Ontario, which represents all of the 30 branches in our network, we recommend a 3% base increase to all the branches, which serve nearly 500,000 Ontarians. This would equate to about an additional $7.4 million to the health budget. CMHA branches have gone without budget increases for as many as eight years.

The CMHA, Windsor-Essex County branch is one of those branches. Any new investment is almost always tied to the delivery of a specific program and not to overall operations. As a result, branches across the province struggle with operational costs such as staff retention, rising hydro rates, administrative expenditures etc. which have an impact on our ability to continue to deliver service.

Sustainability must also come with any new position investments to account for compensation increases over time, thus mitigating an increase to structural deficits and the resulting erosion of services that understandably occurs to address these cost pressures.

The Windsor-Essex branch has mitigated costs over the past three years despite no new funding. You just heard from our esteemed colleagues from Hôtel-Dieu Grace Healthcare. The CMHA Windsor-Essex branch has several integrated leadership positions with our collaborative partner Hôtel-Dieu Grace and has implemented several formal partnerships with community providers in order to develop more seamless care pathways for patients and clients. We need infrastructure dollars to support this very cost-effective, client-focused approach to delivering mental health and addiction care in our community.

Secondly, we need to increase overall funding to erase the difference. We should be treating our mental health the same as we do our physical health. Mental health is a part of our physical health. However, of the $54-billion health budget, mental health and addictions receives only about $3.5 billion, or 6.5%. We actually receive less now than we did in 1979, when we received 11.3% of the health budget.

In alignment with the Mental Health Commission of Canada's recommendation, which points out that other jurisdictions devote 10% to 11% of their funding for mental health, we recommend an increase to 9% from 6.5% of the overall provincial health budget to be spent on mental health and addictions. Funding the community-based mental and addictions sector means you are funding organizations that are innovative and collaborative. We have to be in order to meet some of the challenges we're currently facing. It also means that you're moving towards funding mental health in the same manner as physical health.

We work very hard to keep people out of emergency departments, arguably the most costly model for the delivery of mental health and addiction services. Frankly, it's not where people want to be. We've clearly heard that message from our clients and our patients. Locally, we need to invest in an urgent mental health assessment clinic, which avoids the need for a visit to the emergency department. That clinic would offer a rapid assessment and provide an immediate plan for appropriate supports to avoid an admission to acute care.

It costs $72 a day to house a person in the community with supports versus $485 a day to keep them in a psychiatric facility.

Another cost-effective, client-centered community success story is the Hôtel-Dieu Grace transition stability centre in downtown Windsor, where hard-to-engage individuals can walk in and receive immediate mental health assessment and wraparound supports. The CMHA, Windsor-Essex County branch and Hôtel-Dieu Grace crisis and intake staff will also be launching a coordinated access service next week—a no-wrong-door, single point of access for mental health and addiction services. Sustainable funding for this service is critical.

Community-based funding for mental health and addictions is a good investment. Most importantly, it's where our clients wish to be served.

Thirdly—and you've heard a little bit from some of the earlier presenters—we need to provide greater access to affordable supportive housing. CMHA Windsor-Essex supports the Mental Health and Addictions Leadership Advisory Council's recommendation to expand the supportive housing system for people with mental health and addiction conditions with the creation of 30,000 new units in the next decade, building at a rate of 3,000 units every year. The estimated annual costs to expand supportive housing to adequately meet demand in Ontario is around $278 million in the first year, rising cumulatively to $721 million by 2027. Locally, market rents are increasing, affordable supportive housing is less available and homelessness continues to be a reality for many in our community.

I would also like to take the opportunity to speak about primary care services for a moment, given that the CMHA Windsor-Essex branch is in a unique and enviable position in that we also offer primary care services through our community health centre, City Centre Health Care, collocated with the CMHA. In keeping with our population-based health and health equity focus, our skilled staff primarily serve those in the Windsor and Essex community who struggle with a mental health or addiction issue and require primary health services.

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As a member of the Association of Ontario Health Centres and given our growing role leading comprehensive primary health care, we support the following recommendations:

(1) A 5% one-time base funding investment for all community-governed primary health care teams, amounting to $30 million, in order to address the operational budget freeze since 2012, and then committing to annual budget increases in line with inflation thereafter;

(2) Supporting the performance management and information management program with a one-time investment of $16.5 million for community health centres and $500,000 to aboriginal health access centres to address increased costs, and an annual increase in line with inflation. We need this information management support to demonstrate the improved health outcomes that come from team-based care;

(3) Continuing to expand access to interprofessional primary care teams over the next 10 years by investing $175 million a year for operating costs and $3 billion in one-time investment for capital costs over 10 years to ensure access for some of the most vulnerable people in Ontario who still face barriers to health; and finally

(4) To make upstream investments to build a healthier and more inclusive society, we need to: continue to expand access to oral health care for low-income adults; eliminate the three-month wait for OHIP for new permanent residents, returning Canadians who have been out of the country for over 212 days in the previous year and temporary foreign workers, as a first step in delivering OHIP for all; immediately increase the income support available through social assistance, as recommended in the Income Security: A Roadmap for Change report to the provincial government; and invest in affordable housing and expanding the child care system with enough spaces to meet the needs of all Ontario families.

My key messages today are:

(1) To increase base budgets to address cost pressures and inflationary increases going forward—

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Claudia den Boer: (2) To increase the percent spend on mental health and addictions to 9% of the provincial health budget;

(3) Greater access to affordable housing with the necessary supports for independent living; and

(4) To increase access to interprofessional primary care teams for those who still face barriers to health care.

Thank you very much.

The Chair (Ms. Ann Hoggarth): Thank you. We'll move to the government. MPP Martins.

Mrs. Cristina Martins: Thank you very much, Claudia, for being here this morning and for all of the work and advocacy that the Canadian Mental Health Association here in Windsor-Essex county does. Thank you for that work and for presenting here today.

I've been travelling with the committee all week since Monday. We've hit many different communities across this province and have heard from, I think, by the end of today, about 100 different organizations, associations, union representatives and everyday citizens. Almost in every deputation and every presentation, we hear about the need to address mental health issues in our communities, whether it is in the youth population, in the younger generation—and I'm going to include myself in that—or in the senior population, as we heard earlier.

Before getting into politics, I actually worked in the pharmaceutical industry. One of the areas of focus of the company I worked for was mental health. When we talk about 20 years, 25 years ago—now I'm aging myself here; maybe about 20 years ago—it was difficult to have people acknowledge that their loved one had depression or that they were schizophrenic or that they were bipolar. It was difficult to have a colleague, a spouse, a friend, acknowledge that amongst their family and friends, let alone to stand up and say, "I'm depressed and I need help," or "I'm schizophrenic and I need to search for help."

The woman who presented before you from Hôtel-Dieu said that that stigma has decreased, so there is more awareness. That is so true, in my mind, knowing what this looked like 20 years ago. Even though we have Bell Let's Talk now, there is still some stigma, but not what there was 20 years ago. So there is definitely more awareness.

I don't know that we, as a society, let alone as a government, have been able to adapt to provide the services that are really and truly needed, or the appropriate level of funding.

We do know that in our budget in 2017—I don't know if you want to comment on that. You look like you were jumping in—

Ms. Claudia den Boer: I would love to just take a moment to comment on this whole aspect of awareness, and to really highlight the need to fund mental health promotion. The Windsor-Essex county branch has just launched what we call our Sole Focus Project because we really felt the need to have a focused approach on training, awareness and making sure that people are continuing to feel more comfortable about having that conversation. We know the bubble is around anxiety and depression and we need to be able to talk about it. So thank you for highlighting that because it's such an important aspect.

Mrs. Cristina Martins: In our 2017 budget, we did include an additional new, immediate investment of $140 million over the next three years, and then $50 million every year after that, in order to expand mental health

services, access, the wait times etc. Can you share how this program would help the patients that you see?

Ms. Claudia den Boer: We want to thank you for those additional dollars; we're looking forward to those flowing to us.

What we would see happening is not dissimilar to what Dr. Broga just spoke about, and that is addressing wait-lists.

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Claudia den Boer: We have seen anywhere from a 5% to a 20% increase in referrals across all of our programs, so I think the fact that we're having the conversation is helping. People are starting to reach out. It's more common that people will want to seek professional help, so those dollars will go to addressing access. I would like to encourage the need for that ongoing funding because the needs are increasing.

And then the sustainability, the inflationary increases. I can't highlight that enough because in three years' time what it's costing us to deliver that same service today will have gone up. If we don't address that, we are going to be finding ourselves in a situation where we're going to have to reduce service in order to maintain at least a measure of what we already have in place.

Mrs. Cristina Martins: I think my colleague wants to ask a question. Mr. Colle?

The Chair (Ms. Ann Hoggarth): Sorry, time is up.

Ms. Claudia den Boer: Thank you very much.

The Chair (Ms. Ann Hoggarth): Thank you very much. If you have a further written submission, it needs to be to the Clerk by 5 o'clock tonight.

MS. SJANN JOHNSON

The Chair (Ms. Ann Hoggarth): The next presenter is Sjann Johnson.

Ms. Sjann Johnson: Thank you. Is it okay if I stand?

The Chair (Ms. Ann Hoggarth): Certainly.

Mr. Percy Hatfield: Don't get too close to the mike, that's all.

Ms. Sjann Johnson: All right. Good morning, everybody. My name is Sjann Johnson and I live in Windsor. I thank you for allowing me the opportunity to speak here before you this morning. I would like to just reaffirm that I am not here on behalf of Diabetes Canada or any particular pump or pump supply organization. I'm here as a 56-year-old woman who has had diabetes since 1980.

I'd like to speak to you about insulin pump supplies that are provided for through the Assistive Devices Program that's administrated by the Ministry of Health and Long-Term Care. Currently, the program supplies an insulin pump, such as I am wearing today. This is a $7,000 piece of equipment and it is replaced every five years. It also provides $600 every three months for reservoirs that hold the insulin, and infusion sets, which transfer the insulin from the pump to the body. Would you like me to pass these around?

Mr. Mike Colle: Sure.

Ms. Sjann Johnson: As I suggested, those are very gratefully provided through the Assistive Devices Program.

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There's also the blood meter. When you're on an insulin pump, you test anywhere from four to six to eight times a day. The minimum is four times a day—as well as blood strips. These are accommodated, as well. In my particular case, when I test my blood sugar, this blood meter transfers that wirelessly to the pump, and that helps me make decisions on how much insulin to program to give myself as I eat or if I'm going through a highly stressful illness, low blood sugar, those kinds of situations.

I won't elaborate any more on those items, as they are covered, except I will again extend a huge note of gratitude that the Assistive Devices Program does cover these items. They are life-savers, life-lengtheners.

The pump, the reservoir, the infusion set and the blood meter are four important parts of the puzzle to diabetes management.

The fifth piece of the puzzle is what I'd like to discuss today. This is a blood sensor. It is a computer chip that is inserted under the skin with this device here. There is a transmitter that wirelessly transmits blood glucose from the computer chip itself into the insulin pump. These sensors cost about $325 for a box of five. The Ontario Disability Support Program does cover these for people on disability supports, and I assume—forgive me for not having concrete knowledge of this—that those under 25 will receive the sensors with a prescription. The glucose sensor, as opposed to the glucose tester, is a computer chip. As I said, it is underneath the skin, and it tests the blood sugar every 10 minutes, on the 10s. This allows the wearer to know what the blood sugar is at any given minute. It allows me to know what action is required. If my blood sugar is rising too high, I'm alerted by the pump. It sends an alarm, and then I do what I have been trained to do to lower my blood sugar safely. If my blood sugar is too low—for instance, a dangerous spot for diabetics to be in is if the blood sugar falls too low in the middle of the night—it will alarm, and I will be able to get up and safely eat the carbohydrates I need to eat, and then the sensor will tell me when my blood sugar levels have started to correct themselves.

The business and the medical benefits of blood sensors have been documented very sufficiently in the past, but allow me to share them again. With a blood glucose sensor, one of the benefits will be that a child with diabetes can more safely play soccer. The pump will alert him or her when he or she has played too hard and needs to take a break and have some extra carbohydrates, and then tell them when it's safe enough to get back in the game.

A situation such as I am in this morning, speaking before a government committee, is understandably a stressful situation. Stress, whether physical or emotional, is one of the conditions that can raise blood sugars. What I should have done would be to excuse myself before I even sat down, take a blood test in the restroom and

maybe have done a little bit of a temporary basal, which means that I temporarily give myself a little more insulin, and then that way it accommodates any rise in blood sugar that this sort of situation could very easily cause.

A college student—another benefit of the sensor—can have a sensor. He or she will be able to take those midnight study sessions, maybe the missed meals, much more safely.

A worker can safely look at blood sugar and make decisions about an unusually busy, or even an unusually slow, day.

As far as the workforce goes, I myself believe that sensors can lengthen the work life of an individual with diabetes. Diabetes, of course, causes amputation. It causes kidney failure. In my case, it caused visual limitations which stopped me from doing a job I loved and studying a discipline I loved. I do believe that if I would have had a pump even five years earlier, I could still be working, which means I could be paying taxes and which means I would not be on CPP long-term disability.

If unanticipated activity or smaller meal size is accommodated, the sensor can more safely deal with that.

Blood sugar testing is certainly a major advantage and advance in diabetes management. But, if you will, it is only a snapshot—

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Sjann Johnson: —whether I test four times a day or six times a day or eight times a day. It is only a snapshot of those eight times; it doesn't tell me whether my blood sugar rises or falls in between times. That is the kind of danger of the illness of long-term diabetes. It's those consistent rises in between testing that will do the damage to the eyes, to the kidneys, to the limbs. This is what the sensor will help. I'm going to speak personally now: That will help me monitor. It will give me trends that I can make informed changes on, in conjunction with my diabetes educator and my endocrinologist. I do believe that the sensor can help me retain the abilities I do still have and minimize the chances of further complications, or at least the severity of those complications.

The Chair (Ms. Ann Hoggarth): Thank you.

Ms. Sjann Johnson: Thank you very much.

The Chair (Ms. Ann Hoggarth): We will go to the official opposition. MPP Bailey.

Mr. Robert Bailey: Thank you, Ms. Johnson, for your presentation today. It's one of the more informative ones. I've got some experience with what you speak. My mother lived with it for over 50 years, and I've got many friends and colleagues that are dealing with it on an ongoing basis. I think you gave, in 10 minutes, one of the more informative explanations of how it works.

Now, I missed—I was talking to someone over my shoulder just when you were giving the one part. Do you have the one on your shoulder or the—

Ms. Sjann Johnson: No. That's from a vaccine the other day.

Mr. Robert Bailey: Oh, okay. I was seeing a pharmacist the other day, and he was showing me one that goes on—

Ms. Sjann Johnson: I know. Yes. That's called Libre. I don't know if it is covered. It's kind of in that grey area of a sensor and a long-term blood test. I have yet to find out more information about it.

Mr. Robert Bailey: It was quite interesting. He is a pharmacist. He's type 1, of course, so he checks all the time. He says it has been a real godsend for him because he can check—and every two weeks you change arms and things like that. It was very informative. Like you said, there are so many people who could continue their life and working career etc. if it's treated properly and caught soon enough.

I think my colleague has got a couple of points he wanted to raise. Thank you very much for coming in and explaining this.

Ms. Sjann Johnson: Thank you.

The Chair (Ms. Ann Hoggarth): MPP Barrett.

Mr. Toby Barrett: Thank you for sending around some of the items as well. We do know that there are so many items that are not covered by the Assistive Devices Program. That has to change. That has to be rectified. There needs to be a review of the list to determine what should be added to that list as eligible.

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Secondly, as I understand, the government pays about 75% of the cost and the recipient has to cover the rest, unless they can go to March of Dimes or other organizations that provide wheelchairs, for example, and other products like that. As the opposition, we feel that 75% could be increased; we'd like to see the government cover 80% of the cost.

Those are some of the things that we're working on with respect to not only the kind of materials that you're talking about but so many other programs as well, particularly programs where there is a need with respect to low-income people or seniors. That's why the program is there.

I don't know if there's any more time, if you had anything to wrap up. I've said my piece.

The Chair (Ms. Ann Hoggarth): Two minutes. You're done?

Mr. Robert Bailey: Ms. Johnson, would you like to say a little more? We have two minutes.

Ms. Sjann Johnson: Just that I know that $325 for a box of sensors is a lot of money. My heart and my head say that the savings in a longer working life, in an increased quality of life—the youth that are coming up will have so much less hospital visits, they will spend so much less money on complications. I'm an expensive person to keep alive, and I think if the sensors were covered, there would just be a lot of benefits, not only to the diabetic population but to society as a whole.

The Chair (Ms. Ann Hoggarth): There is one minute, and could you move slightly away from the mike?

Ms. Sjann Johnson: Oh, sorry. I'd just like to thank you all again for your time.

The Chair (Ms. Ann Hoggarth): Thank you for your presentation. If you have a written submission, it needs to be to the Clerk by 5 o'clock this evening.

Ms. Sjann Johnson: I don't have a written submission but I do need my little show-and-tell back. Thank you.

MUNICIPALITY OF BROOKE-ALVINSTON

The Chair (Ms. Ann Hoggarth): Calling our next presenter: the municipality of Brooke-Alvinston. Good morning, sir.

Mr. Don McGugan: Good morning. My name is Don McGugan. I'm the mayor of the municipality of Brooke-Alvinston in Lambton county, about 90 miles more or less straight north of here.

First, I do want to say thanks for the committee taking the time to listen to me. I have been here before. I do have good news for you: I will not be a candidate for mayor again so you won't have to listen to me again. I do say congratulations to all the MPPs regardless of your political stripe. I know you're there for the right reasons: to try to make Ontario bigger, better and, as we hear in the States, Canada first. But anyway, I do say thanks.

On the agenda, it looks as if perhaps I'm the only one from a rural part talking about OMPF funding and some other challenges in Ontario.

After listening to a number of presentations this morning, my concerns—I hate to say this—are really minor. When I hear about mental health challenges, I understand them. I'm working with some in my own municipality, so I appreciate the people I heard this morning.

I realize my time is limited. I did have a handout. If you do take time to look at the handout, I'd ask you to go to page 5. I will get there very, very quickly. I know I talk quickly, but please ask questions at the end or contact me later for more information.

Brooke-Alvinston is a very productive agricultural area. There are 11 municipalities in Lambton county with about $800 million to $1 billion of agricultural produce. Brooke-Alvinston has about $80 million to $100 million of actual raw material leaving our community. We're young, we're aggressive—I'm not young, but they are, and they do a great job.

When I look at OMPF funding, I'm not here—I hate to use the word; I guess this goes in hand. I'm not here to complain; I'm just here to enlighten you on rural Ontario. We do contribute greatly to the assets and the value of our great province. I'm talking about small numbers when you're talking about a budget of—what is it?—$150 billion, with $50 billion going to health care. But in my case, our budget is between $5 million and $6 million. If you look at the chart, in 2014 I was on cloud nine: roughly $1.6 million. Today, we're at $880,000 or $890,000. That's a $613,000 cut. That is over about 13% of our total budget. For us to make that up, it's a real challenge. My own farm taxes last year went up 20%—I'm not complaining, because I have good land; the assessment went up. I'm not complaining. I'm just saying that it did go up that much because of reassessment and we were short money last year.

Also, I do want to say thanks for the money that we got from—even at OMPF, we did get some clean and dirty water money. And we were fortunate to get some real economic development money to do a strategic plan. It's half-done. Some of you may know Bryan Boyle, who was formerly at the Ministry of Agriculture for many years. We're partway through that, and that's a positive experience. And the OCIF funding is a positive, so thank you for that. We are thrifty; we're very unique. Our men weld, they cut grass, they push snow, they run the Zambonis. We are very fortunate that way. If you take a look at that chart, you will see what I'm talking about.

Now, the following two pages: I was dumbfounded when our treasurer told us just a couple of weeks ago that Bill 148 would cost a small municipality about—this is not right on—$70,000. I said, "That can't be right." Well, he did the numbers, and he may be a little high—if you have questions with my numbers later, please get back to me and we'll clarify them for you. But that's a lot of money.

So I'm short $130,000 from OMPF. I have another $70,000, maybe, because of Bill 148, and then that's $200,000. Then we gave our employees, the other night, a 1.5% increase. Some of them thought they wouldn't get any because we had no money—but we did. And then we got another unexpected $50,000 expense, which is not your fault and it's not Brooke-Alvinston's, it's the system. So we are $250,000 to $260,000 short from where we started in 2017. That is a 10% across-the-board bracket—just 10% to get us to where we are today. We really can't do that.

We had a budget meeting on Monday morning and I went through ahead of time of where we could cut. Now, I didn't come up with nearly $250,000 in cuts. I came up with a few. We can't cut the roads, we can't cut the arena, we can't cut the libraries. Now where do we go? Well, we may cut out some services like big pick-up days—we're one of the few municipalities that do that—but that was only $10,000; we're still $240,000 short. So I'm not here asking for $240,000; I'm just saying that with the limit that we have, taxes will go up, I'm not sure by how much. Those are my comments on that part of it.

On Bill 148, I'm going to be really brief. I'm going to tell you right off the bat, I am not opposed to a raise in minimum wage; $11.60 is not enough. I understand that. But to go to $14 in the flip of a switch is too much. I've got four examples here: There's a grill in Alvinston called the Alvinston Grill. They have cut back one day. They do not have any employees other than just family. I talked to the owner yesterday and he inferred—it's open from 6 in the morning until 1 in the afternoon—he may be closing. It's not all to do with Bill 148, but that's part of it.

Then Bob Bailey, my friend here I see from another riding next door to me, is well aware of the Oil Rig. It has closed. It has been there for 50 years. It's a historical part of the oil history in Lambton county in the province of Ontario.

Walmart in Sarnia: A couple of days before January 1, there was a sign at the McDonald's booth that said, "Effective January 2, we'll be closing at 8 o'clock" at the Walmart. That's four employees, for two hours. It works

out to 56 hours a week. Even at $15 or $14, that's about $700 that somebody is not getting.

The Foodland just down the road used to be a 24/7. They stocked shelves at night. They are now open 14 hours. There are less hours and a couple less employees.

So I'm not opposed; I think we went too far, too fast, too quick. I'm not saying that you have to go back. Society likely will adjust; we usually have no choice.

As mayor of the municipality of Brooke-Alvinston, I do have the opportunity to sit on Lambton county council, and I am very interested in that. As you can tell, I'm at the age where I'll be looking to go to a nursing home, maybe in the very near future. I do thank you for the paper that came out, Aging with Confidence.

Many of you will know Jane Joris. She's the manager of our three nursing homes in Lambton county. She also is the president of AdvantAge Ontario. Some of the information in your report is from her and is from AdvantAge.

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I was pleased to see that the government has said that sometime in the future, there will be four actual hours of care for seniors. I think that's great. We're having trouble finding enough employees right now at 3.2. Where do we find the rest? I don't think it's money that's going to bring them. Somehow, our educational system and our colleges have to instill there is a need there. I wouldn't want to be one of those workers. I visit the homes quite often. I had a mother and I had an uncle who had been in there, and I think the people do a great job, but we're short 33,000 beds right now. I see the government is talking about 10,000 beds within 10 years. How do we get there, and then how do we cover the cost?

There's a really interesting number in there—there are more numbers, but the number that got me was that Lambton Meadowview has 125 beds. Their hydro cost in 2017 was some $280,000. It's projected to be $333,000 in 2018. Now, what I did, I just took the numbers and divided by 125, and it comes out to $7 and a few cents per resident for just hydro. They don't cook and they don't heat with it. That does not include the administration, the janitor and other support staff; I just did the number of residents.

I don't know how we're going to continue to go on and afford to be able to provide the needs. I heard the needs this morning on mental health and the other challenges with the diabetes, and I sympathize. My grandmother had diabetes for 60 years. I was just thinking that the machines that this lady had, that would be excellent. But how do we overcome that hurdle of money and providing care to the people who have made this great province such a great place that it is?

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Don McGugan: Yes, one minute.

The other one is the Safer Ontario Act, 2017—I'll be really quick. I have comments in there that I'm not opposed to safety, the OPP act. That's great to take a look at. But it says I need to have a committee in my own community; I've got to have eight people. Does that mean my own local municipality or is that for the county of Lambton? Because in my own municipality, we have a couple of ladies, a couple of councillors, and a couple of other individuals, and we meet twice a year with the OPP and just see where the latest drug houses are. Anyway, what does the government really mean when they say I've got to have eight people, and if I don't do it, they're going to send in a safety consultant and he will set it up? And then the very last sentence on the end of the bill says it never has to be implemented. I would really appreciate to know what it really means. Have you read the bill to the last page?

Mr. Arthur Potts: I have.

Mr. Don McGugan: You have?

Mr. Arthur Potts: I don't think I've seen that.

Mr. Don McGugan: Well, you'd better look at it. If you've got time afterwards, I'll show you.

Okay. Are there questions?

The Chair (Ms. Ann Hoggarth): Thank you, sir. We'll move to the third party. MPP Hatfield.

Mr. Percy Hatfield: Welcome to Windsor to all the committee members to whom I haven't had the opportunity to say that, and thank you for coming on the birthday of my colleague from Windsor West. Happy birthday, Lisa.

Don, thank you for coming to the committee, and Anne, thank you for coming with Don. What have you guys been married: 50 years now or something like that?

Mr. Don McGugan: We're just about six weeks from 50 years.

Mr. Percy Hatfield: That's amazing.

Mr. Don McGugan: And you need to give Anne credit.

Applause.

Mr. Don McGugan: Well, thank you.

Mr. Percy Hatfield: I know how much you have contributed to your municipality over these many, many years on municipal council. I'm sorry to hear that you're not seeking re-election, Don, but I know you've served your community very well, so thank you for that municipal service as well.

Mr. Don McGugan: Thank you.

Mr. Percy Hatfield: When we have talked in the past about the OMPF funding, you have shown me these numbers. You have shown the government these numbers. You have made them very much aware of the impact that the shortfall you've received under OMPF has had on your municipality.

What has been the response when you've talked to the ministers and the Premier about this issue?

Mr. Don McGugan: I'm glad you asked that question, because I've only talked to the Premier twice in my life, and the second time I talked to her, I did mention about OMPF funding. I realize—I forgot to mention this—that there are many formulas to make that work. It's something that has to do with density; I understand that. My population is going down. The Premier said, "Well, Don, you'll have to put taxes up." That was her answer.

Mr. Percy Hatfield: Raise taxes?

Mr. Don McGugan: Raise taxes, yes.

Mr. Percy Hatfield: How much could you raise by a 1% tax increase a year?

Mr. Don McGugan: Twenty-five thousand dollars. That's why that $250,000 is a 10% across-the-board increase.

Mr. Percy Hatfield: So for you to raise $10,000, you have to raise taxes 1%. So if you have a bridge collapse or a culvert collapse—even under one-third, one-third, one-third funding for any municipal infrastructure project, you're talking big, big dollars for your municipality.

Mr. Don McGugan: Yes. On Monday, our roads man, our public works man, said that there's one that we have to replace in the next five years and it's $250,000. Now, we do have some reserves. We're still trying to be fiscally responsible; we have some reserves. But we can't take all our reserves out.

Mr. Percy Hatfield: I know that—and you mentioned it in your written presentation—the Ontario Federation of Agriculture and Union Gas are fighting very hard to expand Union Gas services to your municipality. Will that help keep the costs down for everyone?

Mr. Don McGugan: That does help, but it's a real challenge. I'm working with a young man right now who wants to bring a gas line 12 kilometres. I talked to Union Gas yesterday. They're willing to talk to us, but we're talking millions of dollars. That is a positive. We need to get up and down the main roads. We're not going to get up and down every side road. It's uneconomical. I understand that.

Mr. Percy Hatfield: Also, when we talk to various groups, small and rural municipalities, we're talking about expanding broadband service. You have fibre optic now through Brooke Telecom. Is that enough, or would broadband services help you out as well?

Mr. Don McGugan: Right where I am, we have high speed. The village of Alvinston and the hamlet of Inwood have fibre optics only because of Brooke Telecom, which is a publicly owned company. I'm going to say that we personally are okay. I did put Internet in my presentation for rural Lambton county. Part of Lambton county has no Internet at all.

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Don McGugan: And if I could just make one comment: I did forget, Percy, to mention I should say thank you. The OPP funding formula that we talked about several years ago—I was paying $600,000; it's come down to $400,000. I do want to say thanks. That change has been a positive for us. I want to be honest: There is a saving, that $200,000, for us. You as the government could say you put that towards your OMPF funding. Well, you could, but I spent it on something else.

Mr. Percy Hatfield: In the final 20 seconds or so, Don, thank you for coming. I do hope that the government members have listened about the OMPF funding, and if they could take it back to their caucus and reinforce the need for the government to increase OMPF funding for all rural municipalities. Thank you very much, sir.

Mr. Don McGugan: I say thank you, and if anybody would like to come to Lambton county, we'd love to have you for a day.

The Chair (Ms. Ann Hoggarth): Thank you very much, Your Worship, and congratulations on the upcoming wedding anniversary.

Mr. Don McGugan: Thank you.

The Chair (Ms. Ann Hoggarth): Charlton Heston was married 57 years. They asked him why he thought his marriage had lasted that long, and he said, "Three words: 'You were right.'"

ONTARIO NON-PROFIT HOUSING ASSOCIATION

The Chair (Ms. Ann Hoggarth): I call the next presenter, please: Ontario Non-Profit Housing Association. Good morning.

Ms. Ami Patel: Good morning.

The Chair (Ms. Ann Hoggarth): When you get situated, please identify yourself for the purposes of Hansard, and you may begin your presentation.

Ms. Ami Patel: Thank you very much—

Interruption.

The Chair (Ms. Ann Hoggarth): Just before we begin, if you are having conversations, please take them outside the room. Thank you.

Ms. Ami Patel: Thank you very much for providing me with this opportunity to speak to you this morning. My apologies; I'm just getting over a cold so I will try to project my voice but it may not be as clear.

My name is Ami Patel. I'm the president of the Ontario Non-Profit Housing Association and I'm also the chief financial officer of Windsor Essex Community Housing Corp. here in Windsor-Essex. ONPHA is a member-funded and member-directed association that represents non-profit landlords and local housing corporations throughout the province. Our more than 700 member organizations manage over 163,000 units in 220 communities, and we house some of Ontario's most vulnerable and marginalized residents: those living in or near poverty, fleeing domestic violence, transitioning out of homelessness, or living with developmental disabilities, mental illness, addiction or HIV/AIDS.

The affordable housing crisis in Ontario continues to grow. Recent census data shows that core housing need among Ontarians has jumped 21% since 2011. Rising rental costs are driving more food bank usage. Families are trying to make these impossible decisions between paying rent and putting food on the table for their families.

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A recent Auditor General's report found that approximately 481,000 individuals are currently on the wait-list for subsidized housing. This is an increase of over 36% over the past 13 years and represents 3.4% of Ontario's

population. More and more Ontarians are having trouble making ends meet.

While the need is great, so is the opportunity, and that's why I'm here today. The past few years have seen many important developments for affordable housing. The recent National Housing Strategy that was announced by the Prime Minister signals that the federal government is back in the game in a way that we have not seen in decades. Ontario has undertaken significant initiatives as well, from strengthening tenant protections to expanding housing options for victims fleeing domestic violence, and from working to alleviate chronic homelessness to embarking on the process of modernizing our social housing system. Clearly, all levels of government are committed.

We're encouraged by these developments. They show a real commitment, as well as a clear recognition of the important role that the community-based housing sector plays in a healthy and robust housing system. It's important momentum, and we hope that this continues to deliver on the full potential.

With this in mind, my organization, ONPHA, has four key recommendations for Ontario as we develop the 2018 budget. The first one is to sign on to the National Housing Strategy. The second is to incent and invest in the development of more affordable housing. The third is to prioritize affordable housing development by our sector, the co-op sector and non-profit housing. And the last is to protect existing social housing. I'm going to go through each one of those.

First and foremost, in regard to the National Housing Strategy, it's the first strategy of its kind for our country, and it's ambitious. It's $40 billion over 10 years. Some of the initiatives in the strategy rely on bilateral agreements with provincial and territorial governments. These initiatives will address provincial affordability issues, deliver portable financial assistance to low-income households, maintain the federal government's baseline funding for non-profit housing and public housing in this province, and contribute to protecting and expanding affordable housing.

We encourage the province to enter into cost-sharing agreements with the federal government. The maintenance of federal baseline funding is especially significant, as it will protect rental subsidies for tens of thousands of low-income households that were set to run out over the next decade.

The National Housing Strategy also included a $15.9-billion co-investment fund that is going to be delivered by CMHC. The initiative does not require provincial cost-sharing, but successful applicants will be required to have contributions from different levels of government. It's not specified that they have to be direct funding; they can be other forms of support, such as surplus land, rebates or tax exemptions that could qualify for these lenders. As the 2018 budget is drafted and debated, we urge the province to consider how the province can strategically contribute, to work with municipalities to fully leverage and maximize the opportunities that are presented through this fund.

My second point is in regard to incenting and investing in the development of more affordable housing. Estimates suggest that our province needs to develop at least 6,500 affordable rental housing units per year to meet our population needs. The National Housing Strategy that was announced federally is expected to deliver approximately 2,000 units, so that's about a third. That's still 4,500 units per year that are dropping off. We urge the Ontario government to invest in programs and incentives that would build the remaining 4,500 units each year. It could be done through several measures, such as through the co-investment fund that I just mentioned.

We also recommend that affordable housing programs be supported through revenues that currently exist. Ontario's land transfer tax revenue, for example, generated an estimated $2.8 billion in the 2016-17 fiscal year, and the new non-resident speculation tax has reportedly generated almost $133 million over the first seven months of existence. We recommend that substantial portions of these revenues be earmarked for affordable housing development to increase and preserve affordable housing in Ontario.

My third point in regard to prioritizing affordable housing development by our sector: We recognize that maintaining affordability is not the job of government alone. We have a part to play in that as well. Historically, however, the design of affordable housing programs and capital grants and contributions has favoured private developers who have shovel-ready projects and who can act very quickly.

However, quick delivery doesn't always translate into lasting investment. These initiatives typically ask that rents are required to be maintained affordable for 20 years. So what happens when those 20 years are up? A recent Ministry of Housing study revealed that 90% of private affordable housing developments are converted into condos or they raise their rents when they're no longer required to maintain affordability. When that affordability period ends, tenants are in crisis and don't have anywhere to turn.

On the other hand, our sector, non-profit housing and co-op providers, is driven by boards and an organizational mission that's committed to providing quality, affordable housing for low- and moderate-income Ontarians over the long term. Therefore, we urge the province to design programs that incent development by our sector. This will ensure that important public investments put towards maintaining housing affordability occur in perpetuity. Connected to this, we also recommend that the province help our sector to develop capacity so that we can be better prepared to meet some of these tight deadlines that are required through these programs.

We recently collaborated with the Co-operative Housing Federation of Canada in the Ontario region to articulate the lasting community value of non-profit and co-op housing. I've left copies of that document with my presentation and I hope you take a read through that.

My fourth and final point is to protect existing social housing. While new development is important—we need

those units—we also have public infrastructure that exists today that needs more investment. An estimated 525,000 people are currently benefiting from decades of that investment in Ontario. Social housing makes up approximately 23% of the province's rental market. That's a significant amount.

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Ami Patel: This stock exceeds $30 billion.

Unfortunately, a lot of this stock is aging and crumbling. By our estimate—it's a little bit dated: 2014—our sector requires $2.6 billion in capital repairs for the backlog of repairs and maintenance that is required for these units. Many units are sitting vacant. We hear about this at Toronto Community Housing. We have that issue here in Windsor as well; so does Ottawa. It's essential that these housing assets that public dollars have been poured into continue to be preserved for their use now and for use in the future. Beyond protecting generations of public infrastructure, investing in these assets will also spur economic growth and job creation throughout the province.

I just want to thank you for this opportunity, again, for allowing me to address you this morning.

The Chair (Ms. Ann Hoggarth): Thank you very much. We'll move to the government. MPP Dhillon.

Mr. Vic Dhillon: Thank you, Ms. Patel, for your presentation. Our government has made the supply of affordable and community housing a priority. We're acting to repair social housing and provide flexible solutions to funding stable housing through programs like the cap-and-trade through the CCAP and the investment-in-affordable-housing act.

Are we engaging in the right areas? Secondly, what role do you see the private sector taking on in social housing going forward?

Ms. Ami Patel: I absolutely think the province is moving in the right direction, and I appreciate that question. There has been significant investment by the province through the greenhouse gas fund, through gas tax revenues.

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Many of these initiatives, however, are targeted to reducing greenhouse gases and to creating more energy-efficient buildings and units, which is important because where utility costs are downloaded to tenants who live in social housing, sometimes they may be able to afford their rent, but they're not able to afford their utilities. So those are important initiatives. But what we find to be frustrating in our sector is that after a certain point, there's only so much investment you can make in these energy retrofits, and that directs dollars in a certain way that they would otherwise not be directed. I stated a number, the $2.6-billion capital repair backlog. That doesn't allow us to address that backlog, and that's where the strategic priorities need to be made.

In a year where we would otherwise be working on trying to chip away at that capital repair backlog, because of the funding programs that are available, which we want to take advantage of, what we're finding is that housing providers are engaging in energy retrofits when strategically it would actually make more sense for them to engage in other types of repairs.

Mr. Vic Dhillon: Thank you very much.

Mr. Arthur Potts: Have I got a minute?

The Chair (Ms. Ann Hoggarth): MPP Potts.

Mr. Arthur Potts: Thank you for your presentation. Obviously it's fantastic that we have a federal government in Ottawa that's focusing on this issue—my good friend Adam Vaughan and the work that he's been doing over decades, trying to encourage affordable housing in the city of Toronto and now bringing his expertise to the federal level.

Ms. Ami Patel: Absolutely.

Mr. Arthur Potts: We're working very closely to match it. In my own community of Beaches–East York, we just announced 180 new units with Options for Homes. I work very closely with the Riverdale Co-op and Innstead Co-op. So it's a sector we know that we can continue to invest in to provide affordable housing. And there are other very innovative ways, like Trillium Housing. I'm not sure if you're familiar with Joe Deschênes.

Ms. Ami Patel: Yes.

Mr. Arthur Potts: To take on 25% of the equity in a property to allow lower- to middle-income people the opportunity for home ownership—not just affordable rent, but ownership.

But I wondered if maybe you could comment on the notion of giving people a rent subsidy that's transferrable with them to different communities. We've heard about this request from a few other people. Is that a good way to assist people in affording housing in different communities?

Ms. Ami Patel: We have. The idea of what you're referring to is the portable housing benefit, where the rent subsidy actually travels with the person and is not tied to a physical property or asset. We do believe that that is a positive move. It provides people with choice, and we think choice is important. Traditionally, people have been kind of funneled into these social housing assets that are clustered together, that aren't in the best communities, that are built in areas where there are not amenities.

This allows somebody to take those dollars and say, "You know what? I may be able to live with a private landlord. I will make that choice, and I can take those dollars and move where I want to move. I can live closer to my job. I can live closer to my kids' school or daycare" or whatever it is. So we absolutely think that the portable housing benefit is the right way to go.

In regard to MPP Dhillon's question about the private sector, we do believe that the private sector has a key role to play in this as well. There is a lot of innovation and creativity that's happening there. What we don't see is the long-term investment, and that's what concerns us. The capital grants and loans that are available—it's cheap money to them. It's free equity in a sense. These corporations don't need free equity. They're in and they're out. It's about dollars. It's not about people.

So with regard to your question about the portable housing benefit, we absolutely support that.

Mr. Arthur Potts: Good for you. Thank you, Ms. Patel.

The Chair (Ms. Ann Hoggarth): Thank you very much for your presentation.

Ms. Ami Patel: Thank you.

GREATER ESSEX ELEMENTARY TEACHERS' FEDERATION OF ONTARIO

The Chair (Ms. Ann Hoggarth): I'd like to call upon the Elementary Teachers' Federation of Ontario, Greater Essex. That's a phrase I'm very familiar with.

Ms. Adelina Cecchin: I'm sure you are.

The Chair (Ms. Ann Hoggarth): Good morning.

Ms. Adelina Cecchin: Good morning.

The Chair (Ms. Ann Hoggarth): If you would please identify yourself for the purpose of Hansard and begin your presentation.

Ms. Adelina Cecchin: Sure. Adelina Cecchin, and I'm the local president of Greater Essex ETFO, which represents elementary teachers.

Greater Essex ETFO appreciates the opportunity to participate in these pre-budget consultations. By way of background, our local represents approximately 1,600 public elementary teachers.

Public education is an important cornerstone in our democratic society. It is the promise of equal opportunity for all students in acquiring an education, and when funded properly, it is the gateway to a bright future.

While it is true that the Liberal government has increased education funding since taking office in 2003, this additional funding does not restore the $2 billion in cuts imposed by the former Progressive Conservative government. Public education continues to struggle with these unrestored cuts. School boards must grapple with making budget ends meet, while classrooms absorb the impact of these shortchanged decisions. In a review of the provincial funding formula, economist Hugh Mackenzie reports that Ontario ranks fifth in per-pupil funding in Canadian provinces. Further, Ontario's Auditor General has concluded in her 2017 annual report that the funding benchmarks in the funding formula are out of date and that a full review of the education funding is needed.

Elementary students are further disadvantaged because of the funding differential that exists between the elementary and secondary levels. Per-pupil grants for elementary are funded at approximately $611 less than per secondary student. When applied to the total number of elementary students in Ontario, this amount equates to significantly less funding and opportunities for elementary. This funding differential between elementary and secondary needs to be corrected.

According to the 2017 annual report from People for Education, the average percentage of students per school receiving special education services has continued to increase over the last 10 years. In response, the Ministry of Education effected major changes in March 2014 over these last four years to special education funding. These changes, however, focus on a re distribution of funding to school boards, rather than allocating an increase to funding amounts. Its impact is real: In 2017, there are an estimated 37,000 students in Ontario waiting for professional assessments, IPRCs or placements.

Reduced personnel supports can result in long waiting periods for assessments around proper identification for students experiencing learning or behavioural issues. According to the 2017 People for Education annual report, 64% of elementary schools report restrictions on the number of students who can be assessed each year, an increase from 50% in 2012. Why? Due to budget constraints, boards are forced to limit the number of students that principals can put forward for assessments each year.

As the number of students identified as requiring individualized plans for their learning continues to increase and outpace the grants, more students with special needs are now being integrated into the regular classroom.

The Chair (Ms. Ann Hoggarth): Excuse me. I hate to interrupt, but could you just sit a little back from it, so we don't get feedback?

Ms. Adelina Cecchin: Sure.

The Chair (Ms. Ann Hoggarth): Thank you.

Ms. Adelina Cecchin: The expectations for teachers to meet the wide range of student needs in the classroom along with the required documentation—for example, an IEP—and meeting these commitments are becoming unmanageable. The level of documentation associated with supporting students with special needs is one of the top workload issues identified by a recent provincial study on teacher workload and professionalism.

The move to integrate students with special needs into the regular classroom requires both proper levels of support and adequate planning time in order to effectively meet these needs. Unfortunately, professional supports from educational support staff, behavioural counsellors, psychologists, speech and language pathologists and audiologists are often the first to feel the effects of budget cuts within school boards. The 2017 People for Education annual report indicates that 61% of elementary schools don't have sufficient access to a psychologist and 47% of elementary schools report that CYWs are not available.

Further, growing incidents of violence across the province can be linked to insufficient classroom supports and services. In response, ETFO recently conducted an all-member survey to gather concrete data on the issue of violence in the elementary classroom. These survey results, to be released this month, reveal a startling reality: Elementary educators are regularly faced with disruptive student behaviour, students experiencing serious mental health issues or high-risk behaviours, with little or no support. It is affecting classroom safety, learning and well-being.

Safe learning environments are essential to student learning and achievement. This requires adequate and appropriate funding. The ministry, in fact, recognizes the

importance of well-being and is including student well-being as a priority focus. This focus, however, needs to be broader in scope. A priority on well-being must also encompass teachers and staff. To not include them is to deny what the statistics are disclosing. Provincial long-term-disability claims in the last four years are indicating that the number of LTD claims has increased from 1.36% to 1.88%, with OTIP citing the increase as the result of additional pressure in the school environment. Additionally, WSIB data reflect that the rate of lost-time injuries due to workplace violence is twice as high for elementary teachers as compared to secondary teachers.

1100

Full-day kindergarten for Ontario students is a significant education investment. Preliminary Ontario-based research suggests that this investment is already producing strong results in terms of kindergarten students' early learning reading and writing abilities through the complexity of their drawings, social competence and problem-solving skills. To fully realize, however, the potential of FDK, the Ministry of Education needs to address the issues being identified. These issues include class size, noise levels, and physical space and professional learning to support the teacher and the early childhood educator team.

Although the kindergarten program is funded for an average class size of 26, when compared to the primary cap, the FDK class size is still too large. Primary-aged students benefit from a hard cap of 20 to 1, while FDK students face a class size average—not a cap—of 26 to 1.

In addition, we must consider the developmental differences of these kindergarten students, the emotional and cognitive adjustments, and students who may be experiencing behavioural issues or learning difficulties for the first time in a classroom.

Additionally, FDK classrooms can structurally limit the ability to take full advantage of the play-based program, creating stress and a continued concern with extremely noisy work environments. Cumulatively, these factors impact the physical, cognitive and emotional well-being of students and educators.

The early Ontario research on class size, led by University of Toronto professor Nina Bascia, demonstrates that smaller class sizes enable teachers to provide more individual attention to students and to use a greater variety of instructional strategies. Students with the greatest educational needs benefit most from smaller class sizes, but the improved learning environment benefits all students. Smaller classes improve student behaviour and peer relationships, and increase student engagement and achievement in the early grades.

Based on this research, we should be protecting our smaller classes at the primary level and further expanding to reduce class size in grades 4 to 8. Class sizes in grades 4 to 8 are the largest in the K to 12 spectrum, and yet there is no pedagogical reasoning for this gap.

In order to maintain the invested benefits of smaller class size while moving along this K to 12 continuum, grades 4 to 8 classes must be included. Lowering class sizes in these grades would provide teachers with greater opportunity to develop strategies and interventions tailored to meet the learning needs of each student.

With the recent influx of immigrant families into Ontario, public elementary schools are welcoming immigrant students entering school for the first time. The majority of these students have little or no English proficiency, as confirmed by the annual report from People for Education. This report indicates 63% of elementary schools have EL learners. These students face the challenge of catching up to their peers. Many of these students have experienced trauma or have been without school. Shortfalls in the funding formula have led to school boards needing to use their second-language grants for purposes other than ELL students.

Despite these funding shortfalls—

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Adelina Cecchin: —there are savings to be found in the education sector, savings that can be directly used in the classroom.

For many years, ETFO has identified the government's expenditure on EQAO. In 2012, the budget applied a minimal 2.5% reduction to the EQAO's $34-million annual budget over a three-year period. By 2014-15, however, the EQAO budget had increased beyond the 2012 benchmark to over $36 million. Additionally, it is estimated that the Ministry of Education allocates $142 million to its student achievement division, including $45 million that it transfers to school boards to support their literacy and numeracy initiatives.

Changing the EQAO testing from annual assessments to random sample tests would achieve the goals of both evaluating the effectiveness of the provincial curriculum while achieving education savings.

It is not only teachers who are calling for a change. Leading education policy experts Andy Hargreaves and Dennis Shirley support a move to random sample testing, as does Joel Westheimer of the faculty of education at the University of Ottawa. A random sample is endorsed by People for Education—

The Chair (Ms. Ann Hoggarth): Thank you. We'll move to the official opposition. MPP McNaughton.

Mr. Monte McNaughton: Thanks for your presentation today. I know ETFO and the OSSTF have done a great job at Queen's Park visiting all MPPs and highlighting some of the issues that you're advocating for, specifically—I know it's something I'm seeing in my elementary schools in my riding in southwestern Ontario—this whole issue of violence in the classroom. I'm hearing stories from, obviously, teachers, special education staff members, as well as from parents and students. I wondered if you could talk a bit more about, or highlight again, some of the solutions regarding that issue specifically.

I just want to highlight one thing that's happening in one of the schools in my riding. One of the teachers came to me before Christmas and said, "Monte, we now have to call the OPP on average about three times a week to

come and resolve disputes in the classroom." So I think this is a very important issue.

What specifically needs to be done and what kind of dollar amount needs to be invested to prevent some of these issues?

Ms. Adelina Cecchin: Thank you for your question. I appreciate that you've raised this issue around violence. I know that, for a while, there was a real hesitancy around addressing this issue just because people were uncomfortable about hearing that this is really happening in our classroom. But that is the reality happening across the province. The really scary part is that we're seeing an increase around this violence.

In terms of solutions, there are some concrete solutions that we need to look at, and part of that is the funding piece. What we're seeing is that the special-ed funding that is being allocated to school boards is still not enough, and yet many of these kids who are being integrated into the classroom—because if we look at the stats, it's many of our special-ed kids who are being integrated into the regular classroom—that is the trigger for them.

These kids are being integrated without the kinds of supports that they need—for example, an EA, a CYW, all of those things. This requires funding. We need to be looking at how if the IEP says that this student has to have an EA or some kind of support staff, the funding needs to be there to be able to provide them so that this support remains with this student throughout the school day. So there's definitely a funding piece.

There's also a training piece that needs to happen. I think that across the province, we need to get very serious around a message that safety needs to be a priority in our classrooms. What we're hearing more is that achievement is the primary message. That is important, but we can't get good achievement if we don't have safety under control in our classrooms. So that training piece around policies that school boards have to be following needs to be brought into place.

Also, along with that training, we need to start to recognize that school boards have a responsibility to say that safety matters in the classroom, and that when there are violent incidents that happen in the classroom, the follow-up has to be there. There has to be a follow-up, not in terms of just what's been done, but there needs to be a focus around how we're going to prevent further violence that's going to happen in the classroom.

There's training, funding and definitely a shift in terms of how we're viewing safety in our classrooms. That requires a discussion.

Mr. Monte McNaughton: Have you or ETFO assigned a dollar value request in this budget on that violence piece and the special education—

Ms. Adelina Cecchin: Not that I know of.

Mr. Monte McNaughton: Okay.

Ms. Adelina Cecchin: I know that there is a breakdown, but I think that's part of the discussion that has to happen around how if we're looking at getting this under control—there has to be a discussion around that.

Mr. Monte McNaughton: As far as statistics around this violence issue, is ETFO seeing certain communities—you know, rural versus inner city versus urban schools—where this is more of an issue?

Ms. Adelina Cecchin: You're going to hear more about that. We actually had a provincial survey that was done across the province that had a very good response rate. That information is going to be released.

Anecdotally, I can speak to the larger locals, that there is a—

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Adelina Cecchin: —piece around the violence. I can't speak to the smaller communities, but I know that the smaller communities are also strapped for money.

The other thing, too: There's a real hesitancy around reporting. There are still very much teachers feeling that if we report violence, it's a reflection on how they teach. That's an unacceptable message, because what it's really doing is hurting the learning environment as well as the other students who have to see this violence. What it's doing is normalizing violence in our classrooms. That should be unacceptable.

Mr. Monte McNaughton: Thank you for your presentation.

The Chair (Ms. Ann Hoggarth): Thank you very much and good luck.

Ms. Adelina Cecchin: Thank you.

ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES

The Chair (Ms. Ann Hoggarth): Our next presenter: the Ontario Association of Children's Aid Societies. Good morning. Of course, I know who you are; however, if you could identify yourself for the purposes of Hansard, that would be great.

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Ms. Mary Ballantyne: Sure. Is the mike on? The mike is on. Okay, great.

Good morning, everyone. My name is Mary Ballantyne and I'm the chief executive officer of the Ontario Association of Children's Aid Societies, the membership organization of 48 of the children's aid societies and indigenous well-being societies across Ontario. I'm joined today by Terry Johnson, who is the interim executive director of the local Windsor-Essex Children's Aid Society.

The mandate of the Ontario Association of Children's Aid Societies is to lead its members in developing high-quality, evidence-informed child-protection services that have the confidence of children, youth, families and communities. We're working with members to ensure that we also have the operational capacity to fulfill a unique legislative mandate and are accountable for the public resources that support them.

I'm presenting today on behalf of the members to ensure that decision-makers and leaders in Ontario understand the essential role played by children's aid societies and indigenous well-being societies in keeping

children and youth safe in communities across the province. These organizations have the exclusive legislated mandate to provide child protection services: services for children that have been abused, neglected or are at risk of abuse and neglect. These organizations deliver the protection services 365 days a year, 24 hours a day. They don't have the option of creating waiting lists and are often the only service available when other services have closed for the day.

Even if you know about children's aid, you may be surprised that the majority of child protection work—close to 90% of it—involves working with families to keep their children safe at home. Agency staff work intensely with families whose children have been found in need of protection to ensure that those families have the necessary skills to safely care for their children at home. When they can't be cared for at home, then they are placed out of home. However, only about 3% are actually taken into care; a fraction of these become permanent wards of the province. In fact, Ontario has one of the lowest rates of children in care in Canada.

It's important to know that when child protection services are needed, it usually means that other services have not been available or have not been able to address the chronic health or social experiences experienced by too many families. Having sat here this morning, you've heard from some of those services in our communities. Children's aid must often step in when trauma, mental illness, addiction, socialization, or food or housing insecurity have eroded parental capacity and put children at risk.

In First Nations and other indigenous communities, such chronic issues and service deficiencies are exacerbated by the legacies of intergenerational trauma from residential schools and the Sixties Scoop, the system-wide removal of indigenous children from their homes and communities. The result is the well-documented and significant overrepresentation of indigenous children and youth in the child welfare system.

Child welfare works best when communities are well resourced with the right services to help families get better and bolster their capacity to care for children at home. Ironically, often these services are failing families, and that's when child protection steps in. The province's well-being and prosperity depend on making child welfare and its companion social and health services a fiscal priority.

Despite the essential service that child welfare plays in the social cohesion of Ontario's communities, the child welfare sector budget has been flatlined for over five years.

During this same time, significant system transformation has taken place: A province-wide information management system has been put in place. Three new indigenous child well-being societies have been designated for the care of indigenous children. A shared services program has been established to effect system efficiencies and promote equitable outcomes across the province. Significant resources have also been put in place to respond to communities, critics and oversight bodies, including such things as reconciliation efforts with respect to indigenous communities with a historic apology of child welfare in response to the Truth and Reconciliation Commission, efforts to address disproportional involvement of black and African Canadian children, youth and families in the child welfare system, and also significant efforts to improve workforce competency and local governance capacity.

These efforts have been made with limited new resources. Many CASs are coming now to a place where they can no longer provide the necessary services in their communities within the allocated resources they receive from government.

To this end, the OACAS has some key funding recommendations for the standing committee. The first has to do with indigenous child welfare services and reconciliation. The Truth and Reconciliation Commission, along with the federal Human Rights Tribunal, have provided the necessary evidence and moral direction for all provinces to improve the lives of indigenous people. This includes equitably resourced child protection services so that indigenous communities can look after their own children.

In Ontario, this means properly funding the restoration of the child protection mandate to indigenous communities, as well as the health and social services, housing and other social infrastructure that is unacceptably lacking in many indigenous communities. It also means stepping up to acknowledge the province's role in the Sixties Scoop, and the ongoing harm to indigenous children, youth and families that now requires increased resources for indigenous child welfare.

The second request has to do with the new legislation, the Child, Youth and Family Services Act, which will be proclaimed at the beginning of April. The child welfare sector has advocated for decades for the changes that will soon become law. These include raising the age of protection from 16 to 18, so now this very vulnerable group of youth can receive services, as other children in the province do. The new legislation will also establish an information, governance and privacy regime for child welfare agencies.

These initiatives are welcome, but they do represent significant change management for the sector, which will require new funding. Other public sectors are properly resourced to make this scale of change, and the child welfare system should be no different.

The third area is regarding sector modernization. Investment is required in the child welfare system modernization efforts. The most significant right now is the Child Protection Information Network, CPIN, which will be fully implemented in 2020. However, the costs for full deployment, sustainment and adaptation are outpacing available resources, meaning that agencies now need to use some of their operational funds that they have been using for caring for children to support this system.

The fourth area is regarding funding for the broader service system for children, youth and families. As I said,

you heard from some of those today. As I mentioned, the child protection system depends on the robust social and health infrastructure in communities across the province. Services for both children and adults are needed in the areas of mental health, addiction counselling, housing and food security support, domestic violence support and poverty mitigation. This will help the level of safety and well-being for all Ontario communities. Child and adult mental health require particular attention as key drivers of child protection involvement.

Thank you for the opportunity to present some of the critical issues in children's aid and indigenous child well-being societies in Ontario today. I hope that you will consider the benefits of a well-resourced child protection system for the overall prosperity of the province and the well-being of Ontarians.

The Chair (Ms. Ann Hoggarth): Thank you. We'll go to the third party. MPP Natyshak.

Mr. Taras Natyshak: Thank you very much, Mary and—

Mr. Terry Johnson: Terry.

Mr. Taras Natyshak: Terry. Terry, sorry you didn't get a chance to talk, but we know the great work you do here in Windsor and Essex county. My colleagues Lisa and Percy have had a chance to tour our local children's aid society here, have several meetings and see some of the programming. I was touched; I remember one day I saw a wonderful youth-led play using puppets, talking about abuse and ending the stigma around abuse, and also some bullying issues. I cried, because it is heart-wrenching, some of the stories that our youth have to go through.

I applaud the work that you do and that of your front-line colleagues, because in many respects you are the last resort when, as you've indicated, all of the systems have failed and the resources aren't available in the community, whether it be affordable housing, mental health supports or even chronic health supports in general. Those exacerbate the problem.

Thanks for your testimony. There's so much to focus on. One I would ask: You indicated that the legislation will now broaden the ability for youth in care from age 16 to 18. Has there been any indication by the government that there will be corresponding resources—meaning money—for you to support that increase in age?

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Ms. Mary Ballantyne: Yes. The increase in the age of protection actually began January 1. Agencies were given a small amount to assist with the children who are now coming to our attention. Every day, there are more and more children of that age group coming into the system. They have indicated that there will be some resources beginning in the new fiscal year.

However, what we would want to do is be working closely with government around that to ensure that it's adequate. But also the issues of change management, the change that needs to take place with all of the new processes and procedures: That's where the resources have not been in the way that would really help move this new legislation forward in a way that we would hope.

That would be our hope: that, in this next year, we do see some real resources put into assisting agencies with all of the change that will need to take place in order to really make this new legislation do what we all want it to do.

Mr. Taras Natyshak: When we met at the local children's aid here in Windsor, we were informed about the changeover to CPIN. It seemed an incredible cost that was going to be incurred. Can you talk about the burden that that has placed on regional societies?

Ms. Mary Ballantyne: Sure. There is no doubt that the government has invested in CPIN significantly over the last several years, but when we think about what CPIN is trying to accomplish, there is no question that it would take this kind of investment, and other sectors have had to see this kind of investment. The whole way that child welfare is now doing its work is having to change, in order to accommodate a system that is in place across the whole province and to ensure that we now have a way to get data around all of the children in the province in a consistent way.

First of all, whenever any new technology is put in place, you know there are going to be lots of issues with it, so we are experiencing those and they're being fixed. But they are being prioritized based on resources.

The Chair (Ms. Ann Hoggarth): One minute.

Ms. Mary Ballantyne: Many of those fixes are required in order for the staff to be able to do their job properly. Children's aid societies are now having to backfill and pull from their other resources in order to make this system work.

We want the system. We're confident that, as it continues to mature, it will get us where we need to get to, but we really need the government to continue to invest in it, so that it's not taking away from the day-to-day work of agencies.

Mr. Taras Natyshak: The efforts made to address black and indigenous children in care: Can you talk about any progress and challenges there?

Ms. Mary Ballantyne: Yes. Lots of work has been done trying to support indigenous children, and their communities are really wanting to take back the responsibility that was taken away from them. But in many of the communities, and it's well documented, particularly First Nations communities, as you become more remote, there are really limited resources there, particularly limited treatment resources—

The Chair (Ms. Ann Hoggarth): Thank you.

Ms. Mary Ballantyne: —making the kids have to come to southern Ontario, which is—

The Chair (Ms. Ann Hoggarth): Thank you, and have a good day.

ELEMENTARY TEACHERS' FEDERATION OF ONTARIO, THAMES VALLEY TEACHER LOCAL

The Chair (Ms. Ann Hoggarth): Our next presenter is the Elementary Teachers' Federation of Ontario, Thames Valley Teacher Local. Good morning, gentle-

men. Once you get settled, if you could please identify yourselves for the purposes of Hansard. You may begin your 10-minute presentation.

Mr. Craig Smith: Good morning. My name is Craig Smith. I'm the local president.

Mr. Michael Thomas: Michael Thomas, first vice-president.

Mr. Mark MacLeod: Mark MacLeod, chief negotiator and grievance officer.

Mr. Craig Smith: Good morning and thank you. The Elementary Teachers' Federation of Ontario, Thames Valley Teacher Local, welcomes the opportunity to participate in the 2018 pre-budget consultations. The ETFO Thames Valley Teacher Local represents more than 3,400 public elementary teachers in the Thames Valley District School Board.

My name is Craig Smith. I'm the local president. Presenting with me are first vice-president Michael Thomas, and chief negotiator and grievance officer Mark MacLeod. Together we will focus on three key topics: class size, violence in schools and special education. I do want to underscore that we are not here today asking for more funding. We are advocating greater efficiency in the allocation of existing resources within the education funding envelope.

In the 2004-05 school year, the budget of the Thames Valley District School Board was approximately $500 million. By 2016-17, the TVDSB budget was approximately $1 billion. When we asked our members if they or the students in their care felt $500 million more supported, the answer was a resounding no. Clearly, we need to do better.

Smaller classes, though, improve student behavior, increase engagement and create positive learning environments for all students. Smaller classes also mean that teachers have the opportunity to provide more students with the individual attention they need. To be clear, there is no clear rationale for high class sizes in either kindergarten or in grades 7 and 8.

The primary class size cap is a good thing, but it has contributed to high class size numbers in junior and intermediate grades. It is time for class size equity in the elementary panel. To that end, we are recommending elementary classes K to 8 be hard-capped at 22 students.

Mr. Michael Thomas: Schools are often seen as being a reflection of the society as a whole. However, in a publicly funded institution, we have the opportunity to create and model what we would like to have replicated in society. Unfortunately, violence is on the rise within schools, and school boards are not adequately addressing issues of violence.

While presenting to a budget committee, you would assume that we would be asking for a specific amount of money that the government would need to put into the school system in order for the system to work. However, as Craig mentioned, the current funding model can certainly support the system. Unfortunately, decisions made by school boards are having a drastic impact upon the working conditions of teachers and the learning conditions of our students.

The entire school system is predicated upon one thing: that students are at school to learn. However, students cannot learn in a climate of fear. Classrooms have become war zones, with teachers being sworn at on a regular basis, violently attacked, hit, kicked, having fecal matter and semen thrown at them, and being targeted for harassment by students. Classrooms are being destroyed on a daily basis, and all the time, our students are witnessing and becoming desensitized by this violence. Violence is becoming normalized, and the students are becoming accustomed to witnessing situations that, if they occurred on television, society would consider inappropriate to watch.

So, sitting and presenting to a budget committee, what are the budgetary considerations? Well, consider this: The average cost for paying a supply teacher in Ontario is $235 a day. So for every day a teacher takes off of work, it costs the school board nearly $740, between the teacher's per diem salary and the supply teacher's cost. According to the government's statistics, in 2015-16, there were 123,558 full-time-equivalent teachers and long-term occasional teachers across Ontario. If each teacher were to take merely one day off of work due to an accident or injury or because of psychological trauma associated with suffering from workplace violence, it would cost the government of Ontario $91 million—and that is simply for one day.

Having conducted a survey of our members, the results seem to indicate that the average member takes between four to five sick days off due to workplace stress caused by violent situations. Nearly half of ETFO members on long-term disability are there due to mental health illnesses caused by workplace violence.

These numbers don't accurately reflect the crisis that currently exists in your schools, for there are an additional 35,000 full-time-equivalent employees, such as principals, ECEs and educational assistants who are usually on the front line in dealing with these violent students, nor the thousands of secretaries or custodial staff.

According to the Fraser Institute, elementary teachers average 11.3 sick days, and secondary teachers average 9.6 per year. If our survey results and our LTD statistics are used as a template for comparing sick days used simply because of mental stress dealing with violent students, the government is annually spending over half a billion dollars on sick loss that could be eliminated. By simply ensuring that school boards adhere to their progressive discipline policies and PPM 145, even by reducing sick days by one day for all publicly funded educational employees, the government would save tens of millions of dollars.

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As stated earlier, the current funding model could address this; however, there needs to be a concerted effort to address violence in schools and how violence affects the mental health of employees.

Mr. Mark MacLeod: It goes without saying that special education in our schools is very complex and can take many different forms. Students formally identified with exceptionalities have a legal right to special educa-

tion supports. As well, students who do not have a formal identification also require and access special education services.

According to a report released by People for Education in 2017, an average of 18% of students in each elementary school receive some form of assistance from the special education department. The number of students requiring special education services in our schools has increased dramatically.

Each school board within the province develops its own policy and practices that comply with the Education Act as well as the ministry. From here, many boards develop their own guiding principles that drive the delivery of special education services.

Even though each board is in compliance with the Education Act and its regulations, the delivery and the services available to students vary board to board. These differences are difficult to justify and explain to parents, especially when families transfer boards. For instance, a special education student living in one region of the province may have access to supports up to and including positions in congregated classes. One would figure that staying within the publicly funded education system, similar supports and class placements would be available to the student. Unfortunately, that is not the case.

Children have their own unique patterns of learning, and when provided with the correct environment and supports, all students can succeed. While we can agree that there is some definite upside to inclusion and that integration should be the goal, integration without adequate supports is highly problematic. Unfortunately, integration often resembles the placement of students with special needs in a regular class with limited or inconsistent supports. In those situations where supports are available, we often see two, three or four students clustered together so they can share the educational assistant.

Just as concerning is the reality that some of our very high-needs students qualify for educational assistant support, but only for parts of the day. How is this fair to anyone?

While I recognize the increase in funding that has occurred over the years for special education and applaud the recent increase in support that came out of collective bargaining, a more effective use of these funds may play a big role in solving the special education crisis we are facing. It is a serious issue when students have to wait close to a year to receive an assessment from a speech and language pathologist or up to two years to see a school psychologist; that is, if they are lucky enough to be at a school that actually has a psychologist.

Presently school boards have the flexibility to make their own decisions about allocating funding. Instead of the ministry providing direction on how boards spend these funds, each school board prioritizes their own spending based on their own vision. This leads to a discrepancy of services and supports available to those requiring special education services throughout the province.

Mr. Craig Smith: In summary, the recommendations of the ETFO Thames Valley Teacher Local are as follows:

—elementary classes K to 8 be hard-capped at 22 students;

—school boards be compelled to follow progressive discipline policies and PPM 145;

—that the government of Ontario create a systematic program to eliminate violence within publicly funded schools; and

—that there be independent audits of special education budgets conducted to ensure that allocated funds are being effectively used.

In conclusion, we certainly appreciate the opportunity to speak with you today. The working conditions of teachers and the learning conditions of the students in our care are inextricably linked. We simply ask that prudent decisions are made in the effective allocation of the necessary resources to support both. Thank you.

The Chair (Ms. Ann Hoggarth): Thank you. We'll move to the government. MPP Colle.

Mr. Mike Colle: Thank you for advocating for teachers. Obviously, you're reflecting their concerns, and it's important for us to hear that first-hand.

As you know, all of us have constituencies with many schools. I'm very fortunate; I have some of the best schools in Canada in my riding, rated by the Fraser Institute. These are public schools. They even rate higher than the private schools, where they pay money.

I don't know what it's like in the school you represent, but I think that the public has never before been so positive about public education as I've seen in the last number of years, really. I've been through the Harris years, and I was a teacher myself for too many years.

But anyway, I just want to commend the teachers whom you represent. They have made this difference, to where the public—I've got schools where people are lined up. The most complaints I get are that they can't get into a school because it's filled to capacity, and we're building and expanding.

The one thing I want to ask you is, one of the complaints I do get is, "Why is my kid getting two or three hours of homework in grade school?" What is the elementary teachers' position on kids coming home with all this homework?

Mr. Craig Smith: Clearly, we believe that the work should be done within the school day. There are different opinions on this, teacher to teacher, board to board. Generally speaking, I have to say that, personally, I see no benefit to a grade 1, 2 or 3 student bringing home loads of extra work that is largely done by parents or caregivers. Right?

Mr. Mike Colle: Yes.

Mr. Craig Smith: I think the rule that is followed in Thames Valley is basically 10 minutes per grade level. A grade 1 student might have 10 minutes of work, and from there, it goes up—recognizing that grade 7s and 8s are transitioning to high school and that's a different situation. But certainly for primary and junior kids, there's an ongoing debate about the value of the work that's there.

That said, we do encourage parents to work with their kids, doing things like—I don't know—reading, and some of those things that we just do as part of our parental responsibility.

The FOMO piece? Yes, I have a view on it, which is that less is more in that regard.

Mr. Mike Colle: Yes, I concur with that.

The other thing is, I know you talked about the serious issue about violence that threatens the classroom. It's something that is really up for debate too. The Toronto District School Board has just decided to eliminate the police resource officers in the high schools. I know there are many people who don't think that's a good idea because they feel that the police resource officer keeps away some of the bad apples who prey upon the kids in the school—not so much the kids in the school, but the guys who hang around outside, doing all kinds of things.

You're at the elementary level, but I know this is something that is really a tough nut to figure out. Do we have a police resource officer available or do we not, to curb some of this violence?

Mr. Craig Smith: Each district is a little different. In Thames Valley, every school has a community officer attached. I think one of the concerns that was raised in Toronto was that, potentially, there was perceived to be inconsistency in that, because some schools had them and some schools didn't.

Every school, elementary and secondary, in Thames Valley has a community officer attached.

Mr. Mike Colle: Oh, I didn't realize that.

Mr. Craig Smith: Yes. They do a lot of positive work in terms of interaction with students. Clearly, we hope that our responses to issues in the schools don't always resort back to the police, but there are instances when they do.

To get to the issue of violence in the schools, one of the things that we have been advocating for strongly, for the better part of the last two years, is simply the application of progressive discipline policies that already exist in the boards. These are not zero-tolerance policies; these are simply policies that are in place to provide a structure for learning to take place.

What we don't like to see is a school where there is no discipline, and suddenly the learning culture of the school is the casualty. There's no learning going on, because everybody is putting out fires. What we're working on with our members and with the board is that actual piece: the application of the progressive discipline policies.

This doesn't mean that we don't have situations that are violent or that we don't have aggressive behaviours from students who have particular needs. We're working with—

The Chair (Ms. Ann Hoggarth): Thank you for your presentation. Take care, Craig.

Mr. Craig Smith: Thanks, Ann.

CITY OF LONDON

The Chair (Ms. Ann Hoggarth): Our next presenter is the city of London. Good morning, gentlemen. If you would please give your names for the purposes of Hansard, and your 10 minutes will begin.

Mr. Jesse Helmer: Good morning. I'm Jesse Helmer. I'm joined by Adam Thompson, who is the manager of government and external relations with the city of London.

Chair and members of the Standing Committee on Finance, thank you for the opportunity to appear before you here today. As the largest urban centre in southwestern Ontario, London provides economic and social opportunities for 2.5 million residents of our region. We are embracing our role by providing the infrastructure, jobs and amenities that Ontario families and businesses rely on each and every day.

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To ensure that London and southwestern Ontario continue to prosper, we have identified three key areas for provincial partnership through the 2018 budget: moving forward with rapid transit in London, putting infrastructure dollars to work in our communities and addressing the social and affordable housing crisis, which we certainly are experiencing in London and I know is common throughout the rest of the province.

Our number one priority as a city is bringing rapid transit to London. Rapid transit will help us unlock our full potential as a city. It will connect our world-class education and health care institutions with our award-winning neighbourhoods and employers all throughout the city.

I am delighted to express our appreciation very sincerely to the provincial government for the $170 million in funding that was announced earlier this week. That is absolutely critical, as we know, to moving any major transportation and transit infrastructure program forward, and certainly that's going to help us leverage the federal dollars that we need to complete that program. We are very grateful to have supportive partners on that front from the province.

While bringing transit to London remains our top priority, we are also eager to see the conclusion of the bilateral agreement negotiations between the government of Canada and the province of Ontario as it comes to the second phase of the PTIF funding and other infrastructure programs. Making sure that that is done in a timely way is very important for the actual delivery of the infrastructure programs, which is obviously of key interest to all three levels of government.

The way we travel, the water that we're drinking and the spaces where we connect have a profound impact on each and every aspect of our lives, so getting this plan right for communities is very important.

We are certainly grateful for the provincial government's support through phase 1 of the Clean Water and Wastewater Fund, which has enabled a number of important infrastructure projects. Even in my ward, there are a lot of projects under way now that just would not be happening without that funding. Seeing the exceptional progress that's under way, we're really eager to get work on even bigger projects through phase 2, through both the

PTIF program, the Green Infrastructure Fund and the Community, Culture and Recreation stream.

Public transit investments, in particular, will allow us to make significant improvements to support implementation of rapid transit and permanently change the way people get around our city, particularly in highly congested areas and at places like at-grade rail crossings. We have an at-grade rail crossing that blocks a road that carries about 25,000 people a day, and it blocks that crossing regularly.

Provincial and federal investments through the Green Infrastructure Fund can also support our national and international commitments that have municipal implications. Very specifically, I want to talk about the Canada-US domestic action plan for reducing phosphorus in Lake Erie. Obviously, we have the Thames River running through our wonderful city, and throughout our entire region and the whole watershed the reduction of phosphorus is of major concern. It's something that has been agreed to through these international agreements, but it eventually comes down to the municipalities to deliver on a lot of these fronts.

Making sure that the funding that we need for that is going to actually deliver on a regional basis is very important to the city of London. Certainly, the burden cannot fall entirely on the municipalities. It's one thing for the city of London; it's even more difficult for our rural neighbours who also need to take action on that front. So provincial funding is very important there.

Our third priority relates to providing safe and secure homes for all Londoners. Certainly, we're pleased to see the release of the National Housing Strategy at the federal level, and we see that as a breakthrough for cities and communities. It's very encouraging to see governments at all levels focusing greater attention on issues of poverty reduction, affordable housing and homelessness prevention.

We are leading the way on innovative community partnerships working to end homelessness. Leveraging the strengths in our community organizations is a key element of our own action plan locally. As we say in the community, we are solving homelessness together, and it certainly takes everybody to make action on this very difficult issue.

We have had a supportive partner so far in the provincial government, and the Community Homelessness Prevention Initiative, CHPI, has played a significant role in advancing our local efforts. Recent funding increases mean even more is possible, which is great. Continuing to make progress, however, requires increasing specialization.

For us to move forward in terms of homeless prevention, our community needs the resources to really enable that kind of seamless collaboration between organizations. In particular, we're very interested in moving forward with a centralized intake system that would ensure that information is shared accurately, efficiently and consistently between all the different agencies that are involved, and treat people who are involved in the homelessness system with more dignity and respect so that we understand who people are and we know what their pathway is looking like so that we're not asking them for information over and over again.

Our enumeration efforts and community programs have really demonstrated the power of sharing that information, of making all the organizations involved that much more effective through a fairly simple thing like sharing information.

We are specifically seeking a $1-million provincial investment to create that centralized intake system to support our efforts to end homelessness in London. Many municipalities are contemplating moving to such a centralized intake system. An investment in what we're doing in London, I think, would be replicable across the province, and scalable, so I think that is going to have a good return on the investment if the province were to fund that.

London, like many other communities, is also facing an affordable and social housing crisis beyond the issue of chronic homelessness. We've looked at our social housing stock. We have in the order of 3,200 social housing units in the city of London, and we are looking at a $225-million infrastructure deficit in terms of repair to social housing. Because the social housing was built at similar times, it's all coming due at the same time. The municipal government is certainly not able to cover all of the costs of maintaining that infrastructure—repairing it, and replacing it where it needs to be replaced.

We are seeking a 10-year, $20-million investment from the provincial government as a way to get started on that. Like most infrastructure deficits, the more you ignore it, the bigger it gets and the faster it deteriorates, so making sure we take quick action on that front is going to help us manage the overall cost. It's at $225 million now, and it will get bigger if we don't start dealing with it now.

As the negotiations around the National Housing Strategy continue, we are certainly ready to make sure we can maximize every dollar that comes forward. We have our own funding aligned, but the provincial government's funding is going to be key to actually moving forward on a lot of those issues.

I would really like to thank the committee for having us here today and making London, and southwestern Ontario region more broadly, a priority in the budget process. Full details about the three things we're looking for are available in the pre-budget submission, which I understand was circulated. I would be happy to take any questions you have about our priorities.

The Chair (Ms. Ann Hoggarth): Thank you. We'll move to the official opposition. MPP McNaughton.

Mr. Monte McNaughton: Thank you very much. It's good to see a neighbour. We could have carpooled today down to Windsor.

I just wanted to ask you a bit around the funding on the BRT. Obviously, I've read a lot of media stories on it and heard the announcement from the government. Of course, our party and our leader have said we're going to

respect the local municipal decision on transportation and infrastructure projects.

Where are things at with the federal government? I've heard some mixed messages around where they're at, because obviously you're counting on them to step up to the plate as well. Can you give an idea of maybe a timeline and deadlines and things like this?

Mr. Jesse Helmer: The negotiations for the second phase of the Public Transit Infrastructure Fund are under way now between the governments at the provincial level and the federal level. Until those agreements are negotiated, no funding is going to flow for phase 2. That's where the vast majority of the funding we need for rapid transit from the federal government will come from.

In phase 1, the federal government has already contributed to the rapid transit program, so there's a small portion—I say "small," but I think it was over $10 million—that went into the planning part, but in terms of delivering the actual infrastructure, it will come from phase 2. As soon as the agreements are finalized—I would say that's in the spring; we still have the application period we will have to open—obviously we are ready to go, in the sense that our transit planning process will be over sometime in August. So we'll be ready to go at that point, and we're eager to have that application period open as soon as possible.

It's going to be on some allocation-by-ridership basis. They've already allocated to the provinces on the basis of a ridership and population formula. It looks very promising for the city of London. The question is really on the timing: How soon will it be open and will it allow us to start to actually begin construction on the timelines we'd like to?

Mr. Monte McNaughton: And just for clarification: What dollar amount are you requesting from the federal government?

Mr. Jesse Helmer: It's going to be around $200 million.

Mr. Monte McNaughton: Okay, $200 million.

I don't have any other questions. Thank you very much for presenting today.

The Chair (Ms. Ann Hoggarth): Thank you very much, gentlemen. Have a good day.

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SARNIA LAMBTON CHAMBER OF COMMERCE

The Chair (Ms. Ann Hoggarth): Our next presenter: Sarnia Lambton Chamber of Commerce. Once you get settled, if you could please give your name for the purposes of Hansard, and you may begin your presentation.

Ms. Shirley de Silva: My name is Shirley de Silva. I'm president and CEO of the Sarnia Lambton Chamber of Commerce. I have with me Monica Shepley, our manager of advocacy and policy.

The Sarnia Lambton Chamber of Commerce is a nationally accredited, non-partisan membership organization representing over 700 businesses. Together, our members employ approximately 17,000 workers in the Sarnia-Lambton area. The chamber has been fostering prosperity in our community for 112 years by empowering business to succeed and by initiating major tourism, health and education projects that have a lasting impact to this day.

On behalf of our members and the Sarnia-Lambton community, I thank you for allowing me the time to present to you today on the 2018 budget.

Over 95% of our members own or operate small businesses, and what we are hearing from many of them is that they are worried. They are worried about factors outside of their control that are putting their businesses at risk. They're worried about increasing costs, changing regulations and not finding qualified employees. They worry about keeping up with technological advancements as well as trade negotiations and economic uncertainties. These are not irrational fears. Our world is changing—good or bad—and the uncertainty that entrepreneurs feel is very real.

For example, the renegotiation of NAFTA is causing many businesses to develop contingency plans. Changes may impact tariffs, supply chains, customers and labour.

One item of particular concern is the US call for raising the de minimis threshold for items purchased by Canadians from US online retailers. If the threshold is raised to be on par with the US, that means Canadian consumers would be able to spend up to $800 on Amazon.com tax-free. How can our small retailers compete with this?

We have to understand that if business confidence is low, economic stability is at risk, as well as employment levels and government revenues. Ontario businesses are the backbone of our economy, and the government can provide, through sound financial policies and economic planning, the leadership that makes or breaks business confidence. It is essential that the government strive to provide entrepreneurs with a certain level of stability and certainty so they can plan ahead.

Entrepreneurs are used to taking on risks, and sound businesses have the power to develop strategies that deal with such changes, but to be successful, to compete, they need enough time, stability and supportive government policies so that they can adapt. There are so many uncertainties that it's hard for businesses to plan ahead.

I would like to talk a bit about these uncertainties and what we think the government can do to help with the upcoming budget.

The cost of operating a business in Ontario is a major concern that we share with our members. They have experienced a 71% hike in electricity costs between 2008 and 2016, and now a minimum wage increase of 31.6% between 2017 and 2019.

Carbon pricing, whether it be cap-and-trade or a carbon tax, is increasing costs. It is estimated that businesses pass on about $85 to $200 of these costs per year to consumers.

Labour costs will increase because of the new rules covering on-call, emergency leave and vacation time under Bill 148.

Interest rates are on the rise.

Ontario's combined provincial and federal corporate income tax rate will soon be on par with Michigan and New York.

On top of all of that, small businesses incur 5% to 15% higher costs than larger businesses due to regulations and red tape. These costs impact all of our members right across the supply chain.

We think that government can help businesses absorb these costs by:

—conducting and publishing an analysis of the real costs of doing business in Ontario. If we don't know where we stand, we won't know where we're going;

—lowering the corporate income tax rate so that the combined rate is lower than our neighbours in Michigan and New York;

—allowing Ontario businesses to purchase surplus electricity at rates equal to or better than the exported price;

—providing allowances to companies that had already adopted the most advanced carbon reduction technologies prior to the introduction of cap-and-trade; and

—dedicating carbon tax revenues to R&D where such technologies are non-existent in traditional energy-intensive, trade-exposed sectors.

Another challenge for our members that we would like to see addressed through fiscal policy is access to essential infrastructure. In Sarnia-Lambton, like many other rural or remote areas of the province, we lack access to high-speed broadband and natural gas. We've heard from business owners located in Lambton county that their Internet is so slow that they have to go to the library to get any work done. We still have people and businesses on dial-up. Without adequate access, they are left out of the digital economy. In Lambton, we also have buildings being heated by oil and electricity because there is no natural gas infrastructure. This means added costs and higher carbon emissions. We are pleased to see that the province has invested $90 million in the SouthWestern Integrated Fibre Technology project and $100 million in the Natural Gas Grant Program; however, additional investment is needed to bring fibre and gas to last-mile homes and businesses—today, not 20 years from now.

There is also a need for more reliable funding for municipalities to invest in and maintain bridges, roads and other assets. Funding coming from the province is often competitive, inconsistent year after year, and based on provincial, not local, priorities. Our members would like to see more equitable, stable and formula-based funding for municipalities that is linked to asset-management plans. This would allow communities to plan ahead and decide on their own projects, based on local, not political, priorities.

Finally, I would like to take the opportunity to call on the government to include in the budget funding to develop a provincial framework that supports our emerging bioeconomy. Located in Sarnia–Lambton is Bioindustrial Innovation Canada, a business accelerator that supports the commercialization of bio-based innovations that utilize waste streams. BIC, as it's called, has received funding from the Ministry of Research, Innovation and Science, OMAFRA, and FedDev Ontario. They are at the forefront of the bioeconomy and they are helping Ontario transition to a low-carbon economy. However, to really compete in this industry, Ontario needs to show leadership at the provincial and federal levels. Governments in the US and Europe have developed strategies, but not Ontario or Canada. We would like to see the Ministry of Economic Development and Growth work with the Ministry of Natural Resources, OMAFRA, the Ministry of the Environment and groups like BIC to develop our own framework.

To conclude, we understand that costs will increase and regulations will change, but entrepreneurs require a degree of certainty and time to plan ahead in order to adapt. They are the backbone of the economy, and their confidence can be restored with government policies that support and encourage business growth.

Thank you. I'd be happy to answer any questions.

The Chair (Ms. Ann Hoggarth): Thank you. We go to the third party, MPP Natyshak.

Mr. Taras Natyshak: Thank you, Shirley. It's very nice to see you again. Thanks for coming all the way down to Windsor.

Ms. Shirley de Silva: Thank you.

Mr. Taras Natyshak: It's not that far of a jaunt from Sarnia, but it's great to have you here nonetheless.

You had mentioned several pieces that contribute to the constraints on business growth and economic development in Sarnia and across Ontario, one of which is hydro. I wonder if you've polled the members of the chamber as to how they have responded to the government's fair hydro plan. Is it making a difference? We have heard of figures of up to 25% to 40% reductions for small businesses, but nevertheless I'm hearing from our small business community in Essex county that that doesn't go far enough when they've seen increases of 300% over a dozen years, and 71%, as you referenced, since 2008. That's one question.

Also, I wonder if the chamber has taken a position on the formula around that plan, whereby the government has essentially leveraged or burdened taxpayers with a $40-billion debt going forward to subsidize the $25-billion overall package of reductions that consumers will pay. Do you have a policy position on how that was structured and what will be the ongoing increases of costs?

Ms. Monica Shepley: I can comment on the hydro costs. We haven't specifically surveyed our members on what they've done since the reduction, but in our opinion, we think it's not enough. There are a lot of other costs, so more help is needed. The discussion has mostly been on Bill 148 of late; that's why we haven't heard so much, I think, on hydro. It seems to be the top concern at the moment. But, yes, more help would be needed, I think, for our members.

Ms. Shirley de Silva: In general, small businesses are struggling, and a majority of our members are these small

and medium-sized businesses. Energy is one component, but they are struggling in so many other components as well.

Mr. Taras Natyshak: I'm going to pass it to my colleague from Windsor West.

The Chair (Ms. Ann Hoggarth): MPP Gretzky.

Mrs. Lisa Gretzky: I'm just going to touch on the hydro piece too. I'm going to expand on that a little bit, because you were also talking about not having access to natural gas for heating and such. Certainly my colleague from Windsor–Tecumseh probably knows all too well, because he has many constituents in his riding who only have electric heat; they don't have gas heat. But we know that if you have access to gas heat, as I have in my home, it certainly makes a difference when it comes to your hydro bill.

Do you find that perhaps if hydro costs were under control, if you were paying a fair and reasonable price for your hydro as opposed to the 300% increase we have seen in the last few years, that would help support small business owners? I'm not talking about big corporations; as you probably know, there's a national day of action against Tim Hortons right now. I'm talking about small to medium-sized business owners.

Do you think that would actually help to alleviate some of the pressure that they're feeling in meeting their obligations under Bill 148? Because what I've heard from a lot of small business owners is that they actually value their employees, and they know that their employees should not be living in poverty. They recognize that they should have access to sick days when they need them. Nobody wants their employees coming in to work when they're sick.

The Chair (Ms. Ann Hoggarth): One minute.

Mrs. Lisa Gretzky: But I understand that for the small and maybe medium-sized businesses, it can be difficult to adjust to the new legislation. Do you think that if costs such as hydro were under control, that would help to alleviate some of the concerns for small businesses?

Ms. Shirley de Silva: Absolutely. If costs were under control, it would certainly help to alleviate the concerns of small businesses. But I think that in addition to that, to begin with, no one wants to see their employees come to work sick, or not have a decent wage.

I think the issue is not so much that per se, but it's more in the time that they need to plan ahead. Sometimes a larger corporation can actually switch gears, if you want to use that term, more easily, because they have departments and staff that can do that. An entrepreneur running his own business is busy doing the essential work, and therefore in order to bring about any change, there is a need for a certain amount of time to be able to plan it out—

The Chair (Ms. Ann Hoggarth): Thank you. If you have a written submission that you wish to submit, it needs to be to the Clerk by 5 o'clock this evening.

We stand recessed until 1 o'clock.

The committee recessed from 1203 to 1300.

The Chair (Ms. Ann Hoggarth): Good afternoon. We're meeting here in Windsor today to hold pre-budget consultations. As this is an extension of the Legislature, there can be no clapping, cheering, signs or political material.

Each witness will receive up to 10 minutes for their presentation, followed by five minutes of questioning from the committee. Are there any questions before we begin?

CUPE ONTARIO

The Chair (Ms. Ann Hoggarth): Seeing none, I will call our first presenter, the Canadian Union of Public Employees, Ontario.

Applause.

Mrs. Cristina Martins: No clapping, she said.

Mr. Arthur Potts: Sorry, Chair.

The Chair (Ms. Ann Hoggarth): Mr. Potts, you can go out in the hall.

Laughter.

The Chair (Ms. Ann Hoggarth): Good afternoon, Mr. Hahn. If you could please state your name for Hansard, we will begin your presentation.

Mr. Fred Hahn: Great. Thanks. My name is Fred Hahn. I'm the president of CUPE Ontario. We represent 260,000 public sector workers all across the province in virtually every community, big and small. For years, we've been coming, with others, to discuss what we believe is the urgent need to increase funding to public services, but to no avail.

We are seeing the impacts of inaction in funding all across the province. Hospitals are treating patients in hallways. Child care costs continue to skyrocket, bringing many families to financial breaking points. The school funding formula isn't meeting the needs of students, particularly those with special needs, and it's harming whole communities, forcing the closure of hundreds of schools. Post-secondary education costs are higher here in Ontario than anywhere else across the country. The lack of affordable housing is leaving increasing numbers of people literally out in the cold. The privatization of core services like hydro has not only been found to be financially wrong-headed by independent officers of the Legislature, but it also guarantees that costs will escalate into the future indefinitely.

Our written submission outlines these and other urgent needs that need to be addressed in the budget. But with limited time, I'm going to focus on a couple of key issues.

The crisis in long-term care is a perfect example of what happens when governments starve funding from vital public services. The majority of residents in long-term care in Ontario are over 85 years of age, almost three quarters have some form of Alzheimer's or dementia, and the vast majority have mobility issues. They need significant hands-on care to live in dignity, but staff have only between five and 10 minutes to help each resident get ready in the morning. This includes helping them

from bed, assisting them to get washed and dressed, and to use the washroom. Imagine if you only had five or six minutes to get ready every morning. Now imagine that you're 87 and you have mobility issues.

Seniors built our province. Now they're being treated like cogs on an assembly line, with staff unable to spend the time to assist them with kindness or respect because there simply aren't enough staff to do so. Our seniors deserve better, and it is our obligation to provide them with better.

I do want to thank all parties for voting in favour of Bill 33 at second reading. As you know, Bill 33 would legislate a minimum care standard of four hours of hands-on care every day for seniors in long-term care. That bill calls for a four-hour average for residents in one home, based on their individual needs. Those four hours wouldn't count for those who are not at work, like those on sick leave or vacation, or those who are not delivering hands-on care. And yes, that will cost money, which leads me to my next focus for today, which is revenue.

Year after year, we've come here recommending that the Ontario government needs to raise more revenue because there simply aren't sufficient resources to make the needed investments, not only in long-term care, but in child care, other parts of health care, housing, education—all of the services that our communities need.

I have heard some politicians talk about the solution to this problem: It's finding efficiencies. But frankly, that's simply just a spin line to avoid the real issue. After more than 20 years of budget cuts, there simply aren't enough efficiencies that could ever be found to close the funding gap.

So let's get real and let's talk about what we really need to do. Taxes are our collective way to pay for the important things that our society needs, like dignified care for our aging seniors. But for decades, big corporations and their friends in government have been going on about how taxes are just a bad thing, and look at what's happened as a result to our taxes.

Many of you may have seen a report recently by the Corporate Knights and the Toronto Star. It shows that when individuals and corporations paid an equal share of taxes in our economy, it was robust as ever. But there have been years—decades—of slashing corporate tax rates, and now individuals—the top line—are paying three and half times more in taxes than banks and corporations. That's just wrong.

Our communities' physical and social infrastructure is starting to crumble because governments haven't focused on the things that people need in our province. Instead, they've been more focused on building corporate profits. We need Ontario to thrive and, put simply, that requires governments to stop kowtowing to corporate boardrooms and start serving the needs of people in the province.

Some claim that low corporate tax rates will lead to more investment and more jobs. Again, this recent study, along with so many others, proves that that just simply isn't true. While profits have soared and corporate tax rates have dipped, the level of investment in equipment and job creation over the last number of decades simply has not increased at all.

That's why fair corporate taxes are so important and why investments in public services are so important—because they are great equalizers to make sure that we have what our communities need: real investments, like in this budget, for a guaranteed average of four hours of hands-on care a day for seniors in long-term care, along with others that are listed in our brief.

Thanks very much for your time.

The Chair (Ms. Ann Hoggarth): Thank you. This round of questioning will be the government. MPP Colle.

Mr. Mike Colle: Thanks, Fred. I appreciate the recommendations at the back. I'm sure there's time; we'll go through a lot of those. I know that it's certainly your vocation to challenge us and to direct us as best you can. I think it's a necessary role that you play, and we appreciate it. Although we may not agree and the other parties may not agree, at least we know that you're really passionate about it and it keeps us on our toes, so thanks for doing that every time you've come.

There have been some changes that we have made. I know that you were on the front lines on Bill 148. I think that is a bit of a sea change there. It's not going to solve everything, but do you want to just comment on that one change that has come about?

Mr. Fred Hahn: There are significant changes in Bill 148 that are important, not just for low-wage workers in Ontario, but for the Ontario economy. I think what we're seeing and what I expected I might hear today from some other presenters is a reaction from the business community that will call on the government to lower corporate taxes as a way to mitigate what they're saying are costs associated to them.

I really, dearly hope that you will not listen to that call for reduced corporate taxes. In fact, as I said, this recent study by this group, the Corporate Knights, along with the Toronto Star, confirms what many other economic studies over the last number of years have said time and again: Corporate taxes are actually at a historic low. In fact, we're not seeing the benefit from that, the investments and the job creation that we've always been told would follow.

In fact, government needs money to create services and to help to support the services that are required. There have been many stories over the last while about the rising cost of child care, about how people are served in hospital corridors instead of hospital rooms, and about the real need for patients and residents in long-term-care facilities to have additional care. All of that requires resources, and that means that there are real choices to be made by government.

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So we really are urging you to consider raising corporate taxes in a way that can generate revenue to make the kind of investments that will help in economies and communities, in a way that is really similar to raising minimum wage and improving labour standards and employment standards, as was done under Bill 148.

Mr. Mike Colle: I guess the real pressure along that line is going to come as a result of the reduction in the corporate tax rate in the United States just recently, from 31% down to 20%. I already am hearing that refrain: "Well, you're going to have to now look at that reality in the States to be competitive." So how do we deal with that kind of pressure that we're already getting—the Canadian Taxpayers Federation that was here yesterday talking about this whole thing, and other groups. Editorials will say, "Hey, listen, you've got to do what they're doing south of the border," especially in Windsor here. We just heard Lambton-Kent here talk about the need to be competitive with what services and businesses are doing on the other side of the border.

Mr. Fred Hahn: I think it's a question of what "competitiveness" really means. Businesses benefit greatly when we have good, strong public services, public infrastructure, roads, schools, post-secondary education and institutions that can train the next generation of workers, and a good health care system that helps to offset costs. It's actually kind of an unfair comparison, although I know that it's often tried to be foisted upon us that we would compare ourselves with others, particularly others south of the border.

I think that the government has led by example in relation to the minimum wage. If we were comparing ourselves with minimum wage stuff that's happening in different places around the States, we might not have done what we did. But we understood that it made sense for our economy, it made sense for low-wage workers and it made sense for communities to make this change, just like it would make sense to raise revenue in a fair and reasonable way from profitable corporations and banks, who have soaring corporate profits, who have the ability to make these kinds of additional contributions to our collective economy to make sure that we then have the services that actually help to make us a much more competitive jurisdiction overall.

Mr. Mike Colle: Thank you.

Mr. Arthur Potts: In the last five seconds—

The Chair (Ms. Ann Hoggarth): MPP Potts.

Mr. Arthur Potts: You recommended banning the basic income pilot. Can you give us a quick "why"?

Mr. Fred Hahn: Yes. The basic income pilot doesn't actually resolve poverty. I think the goal that we have, that we share together, is that we want to end poverty in communities. But by giving people some—

The Chair (Ms. Ann Hoggarth): Thank you.

Mr. Fred Hahn: There you go.

The Chair (Ms. Ann Hoggarth): Thank you for your presentation. Have a good day.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Ms. Ann Hoggarth): The next presenter is by teleconference. Ms. Grinspun, are you there?

Dr. Doris Grinspun: Yes, I'm here, thank you.

The Chair (Ms. Ann Hoggarth): Okay. I'm Ann Hoggarth, the Chair of the committee. I will go around the table and tell you who is present. When I'm finished, please state your name for Hansard and also tell where you're coming from. Your brief has been received and has been distributed.

I'm going to describe who's here, and then we will go into your presentation. From the official opposition, we have MPP Bailey and MPP McNaughton. From the third party, we have MPP Gretzky, MPP Hatfield and MPP Natyshak. From the government, we have MPPs Colle, Dhillon, Potts and Martins.

Please state your name and where you're calling from, and you may begin your 10 minutes.

Dr. Doris Grinspun: Thank you, Ms. Hoggarth.

I am Dr. Doris Grinspun. I am the CEO of the Registered Nurses' Association of Ontario, RNAO. I want to thank my colleague Kim Jarvi, senior economist, who worked with me and many others in the association to prepare this submission. I'm calling from Ottawa, where I am at an all-day meeting on being evidence-based, which is very apropos our discussion on the budget and the previous comments, which were very right.

I would like to begin this presentation by urging the provincial government to use a health-in-all-policies philosophy when formulating the 2018 budget. This means promoting an upstream approach that invests in wellness and avoids the human and economic costs of avoidable illness, injury and death. The end result is a healthier society, a safer society, a healthier economy and a healthier budget balance altogether.

RNAO's budgetary requests today will cover four categories: nursing, medicare, social determinants of health and environmental determinants of health. Of course, we will conclude with how we pay for it. And if I don't get there, let me tell you I concur with the previous speaker, Fred Hahn from CUPE, on that issue.

First, let's discuss nursing. To maximize health system efficiency and patient outcomes, it is absolutely essential that registered nurses and nurse practitioners work to their full scope of practice and are used optimally. In the case of RNs, we ask the government to ensure LHINs follow up on the minister's 2017 mandate letter to the LHINs, which says to locate care coordination and care coordinators in primary care settings. The time is now, and we keep waiting for that. This will enhance primary care providers' ability to coordinate care of their patients and help anchor Ontario's health system in primary care, which is a hallmark of the world's most effective health systems—and we are behind.

Much progress has been made to advance the authority of NPs with regard to ordering and applying ultrasound and X-rays, prescribing controlled substances and more. It's absurd that patients need to go somewhere else when they have their NP with the ability to deliver point-of-care testing right there with them. It's not good for patients; it's not good for budgets; it's not good for using professionals. We ask the government to move promptly to allow NPs to perform point-of-care testing, order all

diagnostic imaging, order ECGs in all situations, certify death and complete legal forms for mental health services. Those are several forms, and the priority of many of the parties. Let's move with NPs being able to do that.

Ontario has a shortage of RN positions. Our province is behind by 19,000 RNs to catch up with the rest of the country. Since RNs are required for complex patients, this avoidable shortfall—because it's not a shortage of RNs but of employment opportunities—has caused a growing mismatch between patient needs and the type of nursing care they receive. Accordingly, RNAO asks the province to immediately ensure that all new nursing hires in tertiary, quaternary and cancer care centres be RNs. We also ask that the first home care visits be provided by an RN. The deputy is on board with that. The minister says he is on board with that. Give the directive to the LHINs and others.

At the system level, government must address current LTC funding models—the previous speaker spoke about that—that unintentionally discourage improvements in patient outcomes, because funding, believe it or not, drops when patient care becomes less complex. So here RNAO goes with guidelines to improve care—you have less incontinence, fewer falls, patients become less complex, and the funding gets pulled away. That's wrong, simply wrong, for residents and wrong for the outcomes in the budget.

Ontario's aging population presents important and manageable challenges. Let me stress: manageable challenges. The province's long-term-care homes face a complex population and growing wait-lists. Over 50% of seniors today are over 89 years old, and we have archaic systems of funding. To help the LTC sector meet these demands, RNAO requests that the province legislate minimum staffing and skill mix standards in long-term care, accompanied by the necessary funding to support this change.

We urge no less than one attending NP for every 120 residents. The government has listened and will have delivered 75. We need in every nursing home an NP and a staff mix of no less than 20% RNs, 25% RPNs and no more than 55% PSWs. Today, nursing homes are staffed by 76% unregulated care providers. That's not what Bill 33 means, and that's not what residents need. We need more regulated providers to deliver the outcomes residents need, and in more numbers.

Now I would like to discuss improvements to medicare. Canada has the unfortunate distinction of being the only developed country with universal health that does not have universal pharmacare. Though we were encouraged that Ontario launched OHIP+, and we celebrated, and the minister quoted RNAO that he was taking the first step, that's what it is for us: It's only a first, absolutely amazing step.

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Now we need to move to a universal, single-payer pharmacare program in Ontario covering all medically necessary drugs and associated products, with no means testing, copayments or deductibles for Ontarians of all ages. This is what advanced countries that have universal care do. This is what we need to do. This will result in more efficient use of health system resources, save money through bulk purchasing and ensure no Ontarian has to choose between buying essential medication and putting food on their family's table.

By taking the lead on pharmacare, Ontario could also inspire progress toward a national pharmacare program. Ontario does not need to wait, and so far has not waited. Let's keep going.

Another area where medicare can improve is oral health. About 17% of our province's population cannot afford dental care. You tell me: How do you find a job if you lack your teeth? How do you have good nutrition if you lack your teeth? To a homeless person the other day who I took to eat something, I also wanted to give an apple—no. He couldn't eat a simple apple because he had no teeth. This is not the type of just society that we need. We need people who have oral health. Oral health is part of the body. Teeth are part of who we are.

We must leverage technology and mandate that electronic personal health records, PHRs, be made available to patients in order to increase access to medical information and encourage patient participation in health care decision-making. The time has come. Again, we are behind.

To keep Ontarians healthy, we must also address the social determinants of health. Nowhere is this need greater than in First Nations communities. We urge the province to partner with indigenous nations to address urgent health needs identified by them, such as the ongoing crisis of child and youth suicide.

Ontarians across the province benefited from the January increase in the minimum wage. We urge the government to proceed with the increase to a $15 minimum wage. We still have working poor with the minimum wage we have. If people didn't see that on CBC's The National, please go and see it. This is not a luxury minimum wage; this is what we want if we want an upstream society where people don't just get by, but can actually buy healthy food and have a decent life.

Yet too many Ontarians also still lack adequate housing, which is a critical obstacle to good health—hence why we're dealing with shelters. We need both. We need spaces for shelters. We need to also build at least 30,000 units of supportive housing over the next 10 years—so those also need the support of mental health and addictions issues.

This is critical if we are going to get people out of poverty—

The Chair (Ms. Ann Hoggarth): One minute left.

Dr. Doris Grinspun: How do we pay for that? My colleague said it before better than anybody could say it. Do not—do not—lower corporate taxes. In fact, do not lower taxes for anybody who makes a decent amount of money. If anything, make increases in progressive taxation and close the loopholes to the rich. The time has come. We need the money. We need the money for social programs and health programs for the people of Ontario.

Thank you very much. This is what nurses have to say.

The Chair (Ms. Ann Hoggarth): Thank you. The official opposition will be doing the questioning. It is MPP McNaughton.

Mr. Monte McNaughton: Thank you very much for your presentation today—very well done, and it raised, obviously, a number of important points.

I just wanted to ask a couple of things. In your presentation, you mentioned that Ontario has the lowest RN-to-population ratio in Canada and needs at least 19,000 more RN jobs to catch up. Obviously, because this is a finance hearing, have you assigned a price tag, or how you would see that unfolding from a timeline perspective?

Dr. Doris Grinspun: What we are saying, both from a budgetary perspective and also from a human resources perspective and system stability—we are not saying, "Fire other people." We're saying any new hire to start in acute-care, tertiary, quaternary and in cancer care centres must be an RN. You're not firing RPNs nor PSWs, but if you hire new people by attrition or because we need new positions, you hire RNs. That's how we start to move the system in the right direction. First home care visits must be an RN, simply so you get the health outcomes you need.

Like anything else, if you follow an upstream approach, you will save the money at the end of the equation, because your outcomes will be better, so the investments will materialize also in better outcomes for Ontarians and saving dollars.

Mr. Monte McNaughton: So you don't have an actual dollar amount assigned, like what would be needed on an annual basis to bring the RNs into the system?

Dr. Doris Grinspun: Well, it's very simple to calculate 19,000 by the salary of an RN, but it's not as simple as that, because we're not saying, "Fire other people and pay packages." We're saying new hires in tertiary, quaternary cancer care centres must be RNs, first home visits must be RNs, and hospitals can do the calculation in no time of what they're hiring—our rates. The amount is not huge, but the difference that it makes is actually that you will save money in the dollars; not spend more.

Mr. Monte McNaughton: Okay. Final question: You mentioned OHIP+ and then making a pharmacare program for everyone in Ontario. Has the RNAO assigned a cost to that as well?

Dr. Doris Grinspun: Well, you have the cost already that is public from OHIP+, correct? So what we would suggest with that is that you extend the age access every single year by a percentage, so that in 10 years or in 15 years, we're actually covering everybody.

Mr. Monte McNaughton: Okay. Thank you very much.

The Chair (Ms. Ann Hoggarth): Thank you very much, Ms. Grinspun.

If you have any further written submission, it would need to be to the Clerk by 5 o'clock this evening.

Dr. Doris Grinspun: Thank you very much

The Chair (Ms. Ann Hoggarth): Have a great day.

Dr. Doris Grinspun: I encourage you to see the background that is on our website for every item here.

The Chair (Ms. Ann Hoggarth): Thank you.

LONDON HEALTH COALITION

The Chair (Ms. Ann Hoggarth): At this point I'd like to call the next presenter: London Health Coalition.

Good afternoon, sir. When you get settled, please identify yourself for the purposes of Hansard, and your 10 minutes will begin.

Mr. Peter Bergmanis: My name is Peter Bergmanis. I'm the co-chair of the London Health Coalition. We're a chapter of the broader Ontario Health Coalition, which has brought its concerns to this committee on many occasions in the past.

Again, there's one unassailable fact that we've been hearing over and over again: that Ontario has the fewest beds per person left in the country when it comes to hospital care. Ontario has the fewest nurses per patient in Canada—both RN and RPN—and it ranks at the bottom of the scale for funding our public hospitals by any measurable means, inclusive of population and even as a percentage of gross domestic product.

It seems like a litany that we are always bringing you forward on these updates from the London scene, and that's what I will be focusing on yet again, in this 10th consecutive budget year.

London is a regional medical hub, with two teaching hospitals comprising a combined $1.5 billion in operating budget. Such a sum of hospital dollars taken on its own, without the benefit of historical context, would seemingly paint a picture of a well-resourced medical centre of excellence. However, it must be understood that over the last two decades, London hospital restructuring—which came at a hefty price tag, I will add, of $1 billion—has lost incalculable health care assets.

Ontario has seen massive cuts to hospital beds. More than 18,500 beds—half of the province's acute-care beds and more than half of the chronic care beds—have been cut since 1990. Over 2,000 of those acute-care beds have disappeared from service in the city of London. In addition, the closure of the London Psychiatric Hospital meant 80% of London's psychiatric beds were lost. A vital emergency department and intensive care unit, formerly housed in the core of the city at St. Joseph's hospital, is gone.

The result of this reckless restructuring and massive austerity imposed upon London is a dangerous destabilization of the community's health care services. The budget shortfall, for instance, at London Health Sciences Centre has affected vascular cardiology, mental health, intensive care, oncology, stroke rehab, palliative care and other services. The Cardiac Fitness Institute is the latest medical service to fall prey to cuts, because, as reported in the London Free Press, "These services do not fall under the mandate of acute-care hospitals and LHSC receives no funding to support similar services and can no longer subsidize the costs of the CFI program." Of course, 1,400 patients are now left without.

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Because St. Joseph's Health Care could no longer bear the burden of unfunded transitional care unit beds at Parkwood Institute, LHSC lost a crucial pressure valve for dealing with patient surges in an already overcrowded hospital system. Five additional short-term transitional care spaces have been promised for London, but as of this writing, no location has been identified.

St. Joseph's urgent care centre is routinely overwhelmed with patients awaiting treatment and cannot afford to remain open to the public beyond 6 p.m. In fact, since December 2017, urgent care physicians have routinely taken to rationing care based upon doctor-to-patient ratios without regard for the acuity of the patients. The fewer doctors on duty, the less patients treated and the earlier the department is closed to the public—sometimes as early as 1 p.m.

Hundreds of surgeries are regularly cancelled at all hospital sites due to imposed budget caps. It is commonplace for all hospitals to institute multiple annual OR closures or slowdown periods so as to conserve fiscal resources. Some 25% of surgical suites are commonly out of commission, exacerbating already stubbornly long surgical wait times in a region which struggles with the longest wait times for hip and knee replacement in Ontario.

The situation has deteriorated to the point that officials at the South West Local Health Integration Network are openly reconsidering the wisdom of having downsized the OR at St. Joseph's Hospital. Reportedly, LHIN staff are in favour of moving surgical procedures to a new surgical facility in one of LHSC's smaller buildings so as to combat wait times. Of course, LHIN officials note, "Moving surgical procedures off-site carries the risk of reduced safety for patients and staff, and a reduction in the quality of surgical procedures."

Adding further insult our core Canadian value of egalitarian access to care without consideration of financial barriers, London's hospitals are resorting to creative revenue-generating schemes. St. Joe's OR has been forced to provide dedicated OR time for non- and partial-OHIP-covered surgery as an additional revenue stream. It is reported that private birthing rooms are exclusively reserved at LHSC for those willing to pay. This is an absolute abomination of the principles of medicare.

Hospital overcrowding has had an impact on patients for quite some time now in London. Though it keeps records of hospital occupancy rates, the Ministry of Health does not plan or require that hospitals run at safe levels of occupancy. The consequences of hospital overcrowding warrant more public attention. Within hospitals, overcrowding is associated with serious quality-of-care issues. Overcrowded emergency departments do not have appropriate staffing ratios for critical care or intensive care patients who require intensive monitoring by specially trained staff. Across Europe, hospital occupancy rates have been cited as determining factors in hospital-acquired infections, and indeed Ontario has experienced repeated waves of hospital-acquired infection outbreaks. Cancelled surgeries and prolonged waits are associated with poorer health outcomes.

The dramatic depletion of staffed beds has created code gridlock, with patients waiting longer for beds to become available. The provincial bed occupancy rate is 97.8%, much higher than most other jurisdictions. In London, the LHSC is so chronically overcrowded that it's consistently over 100% patient occupancy. This is neither acceptable nor safe. By some accounts, LHSC has reached the astronomical overcrowding level of as high as 177%. By comparison, most literature would say that 85% is the maximum that any hospital should be at.

Emergency room overcrowding is epidemic among most of our large and medium-sized community hospitals. The unavailability of acute-care beds is a frequently noted factor in ER wait times. Like so many other hospitals in the province, London's emergency departments are chronically filled to bursting. This is not because patients are inappropriately accessing care for influenza or other viruses but, rather, due to a systemic shortage of hospital beds.

The latest available stats from the Ministry of Health and Long-Term Care indicate that patients seeking treatment at University Hospital are likely to wait 13.1 hours for complex conditions, and up to 5.5 hours for minor, uncomplicated conditions. This is well above the provincial norm. The Victoria Hospital site fares little better, registering waits of 12 hours for complex conditions and 5.5 hours for relatively minor ones.

Underfunded, understaffed hospitals have ERs that are bottlenecks. This, of course, results in hospitals where paramedics are forced to wait hours on end to off-load their patients, waiting for care from a nurse.

As a band-aid measure, LHSC administration is attempting to recruit recently retired nurses on a temporary basis to deal with the in-patient overflow.

Then there's the element of the mentally ill patients in the community who are increasingly forced to wait days for admission while languishing in hallways and empty rooms or, worse, still living on the streets. Posted in-patient daily metrics at the London Health Sciences website paint a disturbing picture but do not begin to tell the full story.

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Peter Bergmanis: Through freedom-of-information requests, Londoners have learned that since May 2017, the psychiatric unit has been running at between a 135% and 160% occupancy rate. More recently, the longest wait time over the holiday period was 148 hours, or 6.1 days, to be admitted. This is inexcusable.

Yes, we do appreciate in London that the government gave a 3% increase in the 2017 budget, but unfortunately, that is far from sufficient. What we need immediately, to maintain the level of service provided today, is a 5.2% global funding increase. We need a capacity plan to reopen beds that are staffed on a permanent basis, and services to meet population need.

The current generation of Londoners deserves high-quality, accessible care, and I believe this government should deliver that.

Thank you for your time.

The Chair (Ms. Ann Hoggarth): Thank you, sir. We'll go to the third party. MPP Hatfield.

Mr. Percy Hatfield: Thank you, Peter, for coming in and telling us this tale of too many cities. You're speaking about London, but you could be speaking for every city in Ontario. "It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness...." When it comes to hospital care in Ontario, are we more in the foolishness stage than the wisdom stage at this point?

Mr. Peter Bergmanis: I believe that's a rhetorical question, but I certainly find the folly of how our priorities seem to be skewed towards concerns about how we can cut more revenue out of vital public health care, meanwhile pandering to the corporate sector, talking as if they should not have to pay their share towards what is actually a benefit for all of us. It is absolute foolishness and folly.

Mr. Percy Hatfield: Of all the things that you listed today, all the shortcomings in your hospital system, what burns you the most?

Mr. Peter Bergmanis: That we're actually dealing with people that—you know, these aren't statistics. I'm a health care worker myself. I witness some pretty tragic instances. We've had people turned away from the doors in the urgent care department at St. Joe's. One of those poor souls committed suicide in the parking lot. No services, no psychiatric services that can be attained in a timely manner—this is unacceptable.

Mr. Percy Hatfield: We hear across Ontario about overcrowding in hospitals, and hallway medicine, closet medicine, TV room medicine. Is it that bad in London as well?

Mr. Peter Bergmanis: Beyond a doubt. As you heard from my statistics, 177% over capacity in a hospital—I think that's a record in this country, and a shame.

Mr. Percy Hatfield: Lisa?

The Chair (Ms. Ann Hoggarth): MPP Gretzky.

Mrs. Lisa Gretzky: I actually grew up in London. I've lived in Windsor for just over two decades. I worked in the cafeteria at what we then called UH. It's probably still called that today. That was before they outsourced those jobs. My mom worked in the graphics department and headed that up—which probably doesn't exist anymore—because they used to provide all of those services in-house.

I remember that, then, we were the pride of the province, because we had such great, cutting-edge technology, the infrastructure, we had the medical students and the doctors who were teaching. So we always seemed to be the envy of other municipalities.

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Then I move to Windsor and I hear the story about how our patients, our constituents, are being told to go to London for treatment. It sounds to me, and you would be able to elaborate, that London, which was once the envy of the province, is now pretty much where we are, and any municipality across the province, where you're struggling to provide the quality of care that the patients are needing.

We heard yesterday from Hôtel-Dieu Grace hospital here, which does amazing work around mental health and addictions, that because of the London psychiatric facility closing and the St. Thomas psychiatric facility closing, that has put an incredible burden not only on us down here but on hospitals in London. Maybe you could talk about—and you touched on it—corporate taxes and things like that. Maybe you could talk about what it means when public services such as our hydro system that used to put revenue into hospitals—do you think that's a factor in what we're seeing in our hospital system as far as cuts?

Mr. Peter Bergmanis: Again, it goes back to what priorities our elected governments choose. Unfortunately, over the last neo-Liberal period of time—

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Peter Bergmanis: —we've been faced with the idea that somehow paying fair taxation rates doesn't apply to any kind of services. We're clearly seeing this, be it hydro and the privatization element of hydro, and the deregulation. In health care, it's because we're introducing a lot of private sector schemes as well as bringing them forth, because we are strangulating the ability for the public sector to actually provide those services.

MPP Gretzky, I would concur that all these revenue streams are very vital when we talk about a healthy society. Our hospital system is very much a part of that overall integrated health of our society and our communities. Any single element that is removed is very, very detrimental.

Mrs. Lisa Gretzky: Okay. And I just want to verify that you were promised some new beds last fall, and those beds have yet to open—

The Chair (Ms. Ann Hoggarth): Thank you.

Mr. Peter Bergmanis: Correct.

The Chair (Ms. Ann Hoggarth): Thank you for your presentation.

Mr. Peter Bergmanis: Thank you very much.

The Chair (Ms. Ann Hoggarth): Have a good afternoon.

TOWN OF TECUMSEH

The Chair (Ms. Ann Hoggarth): I call our next presenter, the town of Tecumseh.

Good afternoon, Your Worship. If you could please identify yourself for the purpose of Hansard, and you may begin your presentation.

Mr. Gary McNamara: Thank you, Madam Chair. I'm Gary McNamara, the mayor of the town of Tecumseh and also part of the county of Essex. I want to thank you and the committee for the opportunity to be able to have a conversation in terms of what some of our immediate needs and requests are.

I'd like to, first of all, start with something that's not new to the municipal sector: sustainable revenue streams. Consistent access to revenue tools is important. One of the items that I'm sure you've heard through our association, AMO, is the proposed local share of the

HST, the 1% share; and also the federal excise tax on cannabis. I think we all know that, at the end of the day, that's going to rest on the shoulders of the municipalities for many reasons: social implications as well as the impact of enforcement, and many others.

Also, not unique to just Tecumseh but certainly to this region is that we've had two huge flood events, in 2016 and also 2017. What's happening right now is that many of our municipal residents have now no insurance coverage for their homes because of these two events. There needs to be some government intervention where access to flood insurance for many of these residents should be implemented. As we all know, in the last two years there have been well over $300 million of flood repairs that were required in our community.

As well, the other item of budget consideration—and I know it's a federal issue, but I think it's an issue for all of us—is NAFTA, and how important NAFTA is to this region, in particular, for two things: our manufacturing base in the automotive industry and the supply chain, as well as our agribusiness. This is foodland Canada. This is where some of the largest greenhouse operations in North America are based, with a huge market in the United States. It's critically important for us to protect our trade.

Legal concerns: Again, for the municipal sector, this is something that's not going to be news to any of you. We need to look at the interest arbitration as well as the joint and several liability. Those are two issues that are creeping up for us to be able to manage, in terms of our property taxes. This has been an ask from the municipal sector for many, many years. As Hurricane Hazel McCallion once said, "We're not going away until somebody actually does something about it."

Risk management: The insurance premiums, again, because of that, continue to climb. Court decisions are certainly affecting local impacts.

In terms of the infrastructure piece itself, somehow we need a Canada-Ontario accord signed as soon as we can. We've already lost last year's construction season. If nothing is signed between now and, I would say, April or May of this year, we've lost this construction season. As a good example, in northern Ontario, if you don't have anything in place by September, you just are out of luck in terms of construction activity. We all know we cannot continue to defer our infrastructure. We've got a huge deficit that we need to make up. As soon as that accord can be signed we can get those dollars back into our municipalities.

The other thing as well is to continue to support local economic development. It's a key piece here, especially in our manufacturing.

Also, we need to be prepared for whatever post-NAFTA is going to be. That's not to say that it's all certainly going to be doom and gloom, but I think we need to be prepared for the inevitable, moving forward. Obviously, there is going to be a tremendous partnership that has to be formed between the three orders of government, to make sure that economic development is well supported.

The reinvestment in, obviously, our local businesses and community-driven projects I think is very important.

I know that many think that health care is not a municipal issue, but we all know that the municipal sector in Ontario, through property taxes, pays over $2 billion a year in health care. Our public health services are supported by us. Land ambulance is 50% the responsibility of municipalities. We need to start looking and thinking outside of the box in how we can continue to provide those services to our residents without continuing to push on the property tax base, such as working with our public sector as well, in terms of clinics, partnering with our Ministry of Health, municipalities and local stakeholders.

We need proper funding going forward—obviously, the big one is on the opioid strategy. This is becoming a crisis in our province as well into our own communities. This is not a socio-economic issue; this is something that's widespread throughout our communities. What we're finding now is, it's stretching the resources of our police, fire services, land ambulance and social services, which are also supported by our municipalities. Moving forward, if we are to deal with this issue, which is going to be a long-term issue, we need proper funding at the municipal level to continue to address this crisis.

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Legal concerns: Obviously, I'll go back to the interest arbitration and joint and several liability—I don't want to delve any further into that. You understand that.

Risk management: Obviously, insurance premiums continue to escalate. Good examples of that are many of the programs we've done before, like festivals, for example. We've seen what's happened in Amherstburg. Some of these services—especially in recreation and others that we provide our citizens, our trails etc., which are actually good healthy practices for our municipalities—there are still issues in terms of court decisions and local impacts when the whole joint and several liability piece comes into play. There needs to be some attention at that particular level, because we want to continue to provide those toboggan slides and we want to continue to provide outdoor skating rinks, our trails, bicycle trails and so forth. I know the government is prepared and has been investing dollars in those particular programs, but again, the risk management piece certainly needs to be addressed.

Also of interest for us is—I think I'm just about done, in terms of my piece. I'd like to conclude, Madam Chair, that we need to build on our successes in the process. We need to continue to encourage the MOU province-AMO model. That has worked very well. I know MPP Percy was a member of the AMO board for quite a few years and understands the value of the AMO and provincial model. We need to address the immediate concerns around legislative reforms.

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Gary McNamara: I beg your pardon?

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Gary McNamara: Okay. We need to address the immediate concerns around legislative reforms. We have

to watch, in terms of whatever legislation the government implements, that it doesn't impact negatively on the municipalities. It's one thing to say, "You need to do this," but not having the resources to back that up—it is important. So whatever legislation comes down the line, there needs to be a method of putting a proper testing in there that it doesn't affect municipalities negatively.

We need to continue to work in partnership with the province and also the country to optimize our global market opportunities, such as NAFTA, CETA, Pacific Rim etc. We're not an island within ourselves; we've been a region that is very, very dependent on export, so we need to maximize all of that.

The Chair (Ms. Ann Hoggarth): Thank you. This round of questioning goes to the government. MPP Potts.

Mr. Arthur Potts: Thank you, Your Worship, for being here today to make a presentation. It's great to see you again, no doubt.

I wanted to just quickly start: I haven't heard in the course of these proceedings how small communities like Tecumseh are being affected by the opioid crisis. You always sort of relate that to a large-city problem. So I was quite disturbed to hear that it's an issue that you're facing as well.

Mr. Gary McNamara: This is something that we have to understand, this crisis. It's not a socio-economic type of approach. It's not something that is in a core area of a certain big city. This is widespread. There are two factions to it as well: the illegal importation of the particular fentanyl and those drugs, but also what's being prescribed and what's going into market.

Our own little community has experienced overdoses. We've had deaths in the community. This is around small-town Ontario, rural Ontario. It might not have the same impact of, say, downtown Toronto or even, for that matter, Windsor West, in that area, but it's there. If you look at what's happening in Windsor-Essex as a norm, actually our averages are higher than the provincial average. So it's compounded.

I think the whole thing is that we need to create that awareness, and it's going to take resources for us to be able to do that. It's not just affecting big cities.

Mr. Arthur Potts: No, I appreciate that. Obviously, I appreciate the impact it has on emergency services and public health, which municipalities do deliver. That's clearly an area of concern. We have an opioid strategy that we're working on, but we have to make sure that it gets into the rural, smaller communities as well.

I also want to talk a bit about the NAFTA piece. As you know, our Premier has been very active at the subnational level. There may be a bit of a national-to-national debate that may not be happening, but we're hoping to keep those lines of communication and trade open at the subnational level.

I think that should provide some comfort, particularly for the work that Tecumseh does around greenhouses. I've had the pleasure of touring greenhouses down here. From a climate change perspective, not shipping from California to Ontario, or shipping within your local marketplace, is a huge benefit, not just to the environment but to local economies.

Are there other things that we could be doing to support the greenhouse sector in your community in order to make the fresh produce and goods available to local communities?

Mr. Gary McNamara: The greenhouse industry is more in the southern part of our county, which Tecumseh is part of. Leamington and Kingsville are the large aggregate of those.

My municipality, in particular, is in the tool and mould, and tier 1 and 2 suppliers. We have over 300 shops within our area where 85% of it is dependent on the export market to the United States. There are over 6,000 people who are employed there. These are high-paying jobs and these are high-skill trades. You can see that if the doors close on the export market—in particular, President Trump is wanting to increase the American content in parts—it could drastically hit our community and our region. So it's important that we maintain a fair and equitable trade policy with the United States. Our community is very, very dependent on that.

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Arthur Potts: We look forward to working very closely with you and these subnational jurisdictions, particularly the auto plants on the other side, so that we can make those goods and services continue to flow.

The climate change action plan, the access for municipalities to funds in order to green your own operations in local municipalities—I hope you're engaged. You will be at the ROMA conference, no doubt, this weekend and engage and give us a sense of where it is we can be helping to spend the proceeds. People focus on the cost of cap-and-trade—the three and a half cents a litre—and not so much on the benefits, which are lots of investment dollars to help green our economy. I'm hoping you're availing yourselves of those programs.

Mr. Gary McNamara: We certainly are. I know there's a time issue here. I can tell you that our municipality just received an environmental award from our conservation authority yesterday because of our engagement in climate change. We're not sitting idly in terms of dealing with the climate change. The flood mitigation pieces that we're putting in play ourselves—our community has invested close to $40 million. We're doing our thing.

Mr. Arthur Potts: Excellent. Well done.

The Chair (Ms. Ann Hoggarth): Thank you, Your Worship, for your presentation, and have a good weekend.

HOME CARE ONTARIO

The Chair (Ms. Ann Hoggarth): The next presenter is Home Care Ontario. Good afternoon.

Ms. Sue VanderBent: Good afternoon.

The Chair (Ms. Ann Hoggarth): If you could please state your name for the purposes of Hansard, you may begin your presentation.

Ms. Sue VanderBent: Thank you very much, Madam Chair. My name is Sue VanderBent, and I am the CEO of Home Care Ontario, the provincial association representing providers of care across the province. Thank you very much for this opportunity to present to you today.

Eighty-seven per cent of people over the age of 55 tell us that they want to live at home, they want to receive care at home and they want to, if they can, end their last days at home. People want and need more home care, but three critical factors are affecting that. Growing patient complexity—I think we've heard a lot about that from previous speakers; an aging population, which we all know about; and continuing underinvestment in home care mean that people are actually getting less care than ever before in home care.

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Families are struggling to look after their loved ones and are often going to the ER in desperation. We see a lot of those cases. Our hospitals are reporting overcrowding, constant strain, growing ALC rates, and hallway medicine. Long-term-care homes are reporting higher and higher acuity because a lot of people are deteriorating in the hospital while they wait to go home—and then they can't actually go home; they go to long-term care.

The Chair (Ms. Ann Hoggarth): Excuse me. Could you just get a little closer to the mike? We're having a hard time hearing. Thank you.

Ms. Sue VanderBent: Yes; sorry.

These are the two indicators of a health care system that is under extreme pressure because the sectors are interdependent. Each one depends on the other for their performance.

The total proportional spend on home care is 5% of the Ontario budget. This percentage has actually not changed in 20 years. To put that in perspective, we spend $2.7 billion on home care out of our $54-billion health budget in total. It is essential that Ontario invest more in home care to reduce hospital overcrowding, keep seniors in their homes longer, and free up resources for hospitals and long-term care for those who truly need it.

I respectfully ask the committee today to consider the following recommendations for home care:

Invest an additional $600 million annually in our home care system to deliver more front-line care. This would mean nine million more PSW visits, five million more nursing visits, and funding to begin to meet the needs for skilled therapies and other home care services that we are going to see with the kinds of demographics that we're expecting.

Here is the recommendation where I ask the government not to spend money. I ask the government to eliminate the plan to create a new parallel agency for self-directed care, and to work with existing providers to integrate care and to implement a truly quality-based, self-directed care for Ontarians that need it. We certainly agree that there are those patients who do require that complexity of care and don't fit into the usual care. But we do not think that we need to spend more money on bureaucracy instead of giving care directly to people in the system that already exists.

I ask you to work with health system leaders to implement a comprehensive health human resource strategy to recruit and retain more home health care workers and launch a public awareness campaign through social and online media to help our public understand the risks that they take when they do not hire care from reputable providers who have good health human resources and occupational health and safety standards and are accredited. This is unsafe and unregulated care that people often turn to, but it will result in more ALC crowding, because if a person is being looked after by an unsafe, unregulated person, that person will have to go to the ER in some trouble.

We ask the government to consider implementing a tax credit or caregiver allowance for those Ontarians who can and do wish to purchase additional care to supplement the publicly funded system to look after their loved ones, purchasing care from organizations that have health human resources and occupational safety and accreditation standards.

We ask the government to invest in technology to strengthen the information exchange between front-line home care and the rest of the system, like our ERs and our family doctors. Right now, most people don't know that the front-line home care system is not directly connected to our ER doctors, to our family doctors and to the rest of the system, and that needs to change.

It's essential that we begin to invest in home care to address and reduce hospital overcrowding. We know that the numbers are going to increase. By 2036, our senior population will double to four million, and people aged 75-plus will be 144% greater. The government has promised to open up more transitional beds and hospital beds in a short-term interim, but the reality is that given the demographics, we do not think that this is going to really help. Those beds will fill up, and we need home care. People have beds at home; we have a home care system that could care for them at home.

At the conclusion of my statement, I would say we have to think of different ways to transform our system and embrace new ideas and solutions. Home care is one of those solutions. We have plenty of ideas that we would like to share with you. Putting home care at the centre of your system will truly help people achieve what they really want to do in the first place: stay at home, live at home, receive care at home and, if possible, die at home. Thank you very much.

The Chair (Ms. Ann Hoggarth): Thank you very much. We move to the official opposition. MPP Bailey.

Mr. Robert Bailey: Thank you very much for your presentation this afternoon, Ms. VanderBent.

This is something that presents at my office quite regularly: people who are in alternate-level-of-care beds at the hospital, and then they go to be released and they don't have the support at home, but they want to go home. The kids are saying, "No, she's not ready to go home." The mother says she is. Then we have occasions

where they have to re-enter the hospital system, and that bed's already occupied because there's someone waiting to go in it already. Like you said, there are a number of people who are in hallways, and they move into that ALC bed immediately as soon as that person leaves.

I think the more we could do to keep people—like you say, most people want to be at home. If they have the types of services and the type of support that could keep them there, they're happier at home. As long as they know they're getting the proper care, I think their families would be happy to have them at home as well. As we always say, one of the last places you want to go to visit is a hospital, because that's where all the sick people are, right?

I like your ideas. Certainly, it's a great presentation that you've put together here. I don't know whether you've got anything else you would like to say in conclusion, but I don't have any more questions. I just want to applaud you on the work you've done, and the opportunities that are out there for people in Ontario.

The Chair (Ms. Ann Hoggarth): Did you want to say anything else?

Ms. Sue VanderBent: Thank you very much for the opportunity. I'm certainly happy to speak to government or the official opposition about any of the ideas that we would have to bring forward.

The Chair (Ms. Ann Hoggarth): Thank you.

CANADIAN CANCER SOCIETY, ONTARIO DIVISION

The Chair (Ms. Ann Hoggarth): Our next presenter will be the Canadian Cancer Society, Ontario division. Good afternoon.

Ms. Bonnie Fraser: Good afternoon, Madam Chair and everyone else.

The Chair (Ms. Ann Hoggarth): Please state your name for the purposes for Hansard, and you may begin your 10-minute presentation.

Ms. Bonnie Fraser: My name is Bonnie Fraser, and I am here today to speak on behalf of the Canadian Cancer Society as a volunteer. I was called in last-minute for this. I am a resident of Ontario and someone who is actively engaged in the fight against cancer.

With an estimated one in two Canadians developing cancer in their lifetime, we could all stand here to speak on this issue, as we have all been affected by this terrible disease in some way. That is personally true for me. When I was 22 years old, my husband was diagnosed with cancer. He was an American student and had to go back to Buffalo. We didn't have the money, because I was making $6,000 a year as a first-year teacher, and the Canadian Cancer Society stepped in. This is why I have been volunteering for them for 35 or so years.

I would like to present two of our priority recommendations as outlined in our written submission. These recommendations would be the most efficient and effective way to limit the prevalence of cancer and to help those who are currently living with cancer.

The Canadian Cancer Society recommends that the government of Ontario, firstly, fully implement the recommendations made by the Executive Steering Committee for the Modernization of Smoke-Free Ontario in its report submitted to the Ministry of Health and Long-Term Care by (1) increasing the provincial taxes on tobacco products, and (2) investing in an integrated tobacco-cessation system; and, secondly, address the concerns raised by the Auditor General of Ontario report which outlined some of the current issues experienced throughout the cancer treatment system, by investing in a system to fully fund take-home cancer drugs and by investing in patient support services.

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Concerning tobacco control: Last spring, the Minister of Health and Long-Term Care established the Executive Steering Committee for the Modernization of Smoke-Free Ontario, with membership from across the spectrum including health, public health, government representatives, academics and patient organizations. This panel was struck to "make recommendations that are: grounded in evidence and best practices, culturally appropriate, responsive to priority issues, and aligned with the government's strategic vision and priorities." The ultimate goal of the modernization recommendations is to achieve less than 5% tobacco use by the year 2035.

The first step highlighted by the committee in its report is to challenge and contain the tobacco industry, and the best way to do this is to increase tobacco taxes to match those found in other jurisdictions. Currently, the province of Ontario has the second-lowest tax rate on tobacco products, even considering the upcoming proposed raises on tobacco taxes. That's available in a graph on page 4 in the submission. Importantly, the proposed tax increases announced in last year's budget need to have a fixed date of implementation to ensure the measure is as effective as possible.

Increasing the tax paid on tobacco we know leads to as much as an 8% drop in tobacco use among youth specifically, and 4% among the public in general. Price is a significant barrier to new smokers ever starting and helps encourage current smokers or tobacco users to quit. How many of us have heard from friends who said, "You know, when the price of a carton of cigarettes reaches"—if you're old like me—"$10, I'm going to quit" or "When it reaches $20, I'm going to quit." Well, the tax alone on a carton of cigarettes right now is almost $33, so those are definitely—and it's going to go up by $10 in the next three years. It is an excellent first step to take when trying to reach the bold benchmark of less than 5% tobacco use by 2035.

Stopping new tobacco use, though, is only half the battle, as Ontario must invest in motivating and supporting more than 80,000 current smokers to quit each year to reach that target. An increased price will help but is insufficient on its own. To truly have a health impact, it will take the province of Ontario to invest and support a comprehensive, integrated tobacco-use cessation system.

There are several models currently used throughout the province that have proven to be effective in helping

tobacco users quit: the STOP program, the Ottawa model, and the Canadian Cancer Society's Smokers' Helpline. The STOP program is a public health unit initiative, the Ottawa model was from the Ottawa heart institute, and the Smokers' Helpline is the Canadian Cancer Society's program that deals with people who want to quit smoking and they have their own private quit coach, and they support them by text, by chatting and by talking to them.

Each of these evidence-based programs supports smokers through their efforts to quit smoking and using tobacco. However, due to their individual development, these programs have not been fully integrated to facilitate referrals and information-sharing among the programs. For example, Smokers' Helpline is integrated with the Ottawa model, but not yet with others, even though an integrated model has been proposed by the three major programs to the Ministry of Health and Long-Term Care.

Ensuring that these programs fully integrate with each other would create a user-centric system that puts patients first and allows them to utilize the best service for them at that moment, wherever they may be located in the province. Creating a single cessation strategy province-wide is a necessary and effective step to achieving our goal of less than 5% tobacco use by 2035.

Concerning take-home cancer drugs, mitigating the risk of cancer is an important step to manage the impact cancer has on the public, but we must not forget about supporting those who are currently engaged in the fight of their life, whether that be through cancer treatments or emotional support services.

A cancer diagnosis comes with a wide variety, a wide array, of stresses and concerns that patients and caregivers must navigate. The least of these should be how to fund their treatment—

Interruption.

Ms. Bonnie Fraser: Should I go on?

The Chair (Ms. Ann Hoggarth): You're just going to have to speak up, please.

Ms. Bonnie Fraser: Okay.

However, due to the current system, patients across the province are struggling to find the necessary coverage to receive the drugs they need to save their lives.

Many cancer medications are administered by IV in the hospital and covered by the government because they're taken in a hospital setting. However, most new cancer medications are oral drugs made to be taken at home. Take-home cancer drugs are either covered by group or private insurance, or paid out of pocket by individuals, or covered through a provincial government program for individuals who qualify. The last thing a patient needs to go through after diagnosis is trying to figure out which of the latter programs may or may not pay for the drugs they need to fight their cancer.

Recently, the government introduced OHIP+ to provide no-cost prescriptions for anyone under the age of 25. While OHIP+ is a welcome step forward for cancer patients, it still leaves a large segment of the population, those 25 to 64, in a precarious position. Even the recent Auditor General report stated the challenges that need to be addressed in funding take-home cancer drugs.

As we head towards the 2018 provincial election, there's a golden opportunity to address this issue for good. It is rare that we have political consensus, but over the last few months that some of the parties have released their election platforms, we have seen this issue rise to the top as a priority for whoever forms the next government.

I'd like to take this opportunity to urge the government of Ontario to follow the lead of the western Provinces, close the gap and fund take-home cancer drugs for all Ontarians, because cancer patients cannot wait.

In conclusion, our budget recommendations outlined above are concrete steps that can be taken to slow the growing prevalence of cancer and to provide the needed support for those currently battling the disease. I urge the government of Ontario to implement these steps in its 2018 budget. We stand ready as a partner to work with government as it works to build a healthier Ontario.

Thank you for your time today to address the issues that have been identified as priorities for the Canadian Cancer Society.

The Chair (Ms. Ann Hoggarth): Thank you very much. We'll move to the third party. MPP Gretzky.

Mrs. Lisa Gretzky: I want to thank you for coming today and presenting even though you weren't originally scheduled to be the presenter. You did a fantastic job.

You mentioned OHIP+ and the take-home cancer drugs and how you think the coverage should be expanded to those over the age of 25 so that they can also be covered for their take-home medication.

We support universal pharmacare. That would be for everyone, not just those under the age of 25. I know you're here to represent the cancer society, but do you feel that medication should be available to everyone over 25—not just the take-home cancer drugs, but expand the list of medications that would be available? In my father's case, there were other medications that he had to take, not just those for his cancer treatment.

Ms. Bonnie Fraser: I cannot give an opinion of the Canadian Cancer Society—as volunteers, we're severely restricted on that.

Our concern is that, yes, we know that you're thinking of going through pharmacare for that, but the cancer patients can't wait for that federal program. They need it now. So we need the province to step up and say—and I've noticed when I go out and do outreach with people and talk to them about these things, and try to get signatures to say, "Yes, we want Ontario"—they are aghast that the western provinces support that and Ontario doesn't. They want to know why we are left out.

Mrs. Lisa Gretzky: I'm going to ask you a question, but you may not be able to answer it. You talked about increasing the taxes on tobacco. I'm wondering if the Canadian Cancer Society has given you any indication of what that might look like when it comes to contraband tobacco. Do they feel that maybe there would be a rise in

contraband tobacco use if they raised taxes on tobacco that is legal?

Ms. Bonnie Fraser: Yes, they do. That is addressed on page 4 of the submission, under the graph. Because I was new to this, as you are, I had to study this as you would have to, so I had a lot of the same questions you do. The Ontario Tobacco Research Unit, which comes out of the University of Toronto, has come up with a study that says that with increased tobacco taxes, of course there will be an increase in revenue, there will be a decrease in tobacco usage and, for a marginal amount of time, there will be a temporary increase in the use of contraband tobacco.

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The tobacco industry doesn't walk the talk that they say about taking care of contraband tobacco, but there are solutions that are available. That happens to be on page 5, in the middle of it.

There are seven other provinces that do this differently. When Ontario sends the gasoline to the reserves, they have a refund/rebate system in place for that so that Ontario taxes are collected before it's sent, and then if legitimate First Nations people use it, there is a refund provided to them. That's what we're suggesting they do for tobacco. As it stands now, that's not the way it works.

Mrs. Lisa Gretzky: Okay. That was going to be my next question: Is there a way here in Ontario to ensure that what laws we have are actually enforced? Are there the resources to enforce them and also to really take measures to ensure that anybody who is using this contraband tobacco who isn't supposed to have access to it doesn't have access to it, but those who are legally allowed to have access to it are not being penalized for the ones who are not supposed to have access to it?

The Chair (Ms. Ann Hoggarth): One minute.

Mrs. Lisa Gretzky: Was there anything else that you wanted to add in the last 30 seconds?

Ms. Bonnie Fraser: There really is. There really, truly is. From doing presentations about screening and prevention, I know about the survival rates for cancer—five-year survival rates. I know that for colorectal cancer it's 95% if you get it soon enough. For prostate cancer, it's 95%—same thing. Breast cancer has gone up to 87%. But lung cancer is a dismal 17%. We haven't had improvements in it, and the improvement is going to be to get people to stop. That is going to have to be the major solution for that.

I also decided, "Okay, what about the price for you to consider?" A Conference Board of Canada study released last October said that smoking causes one in five of all deaths in Canada—

The Chair (Ms. Ann Hoggarth): Thank you. Thank you for your presentation.

Ms. Bonnie Fraser: Thank you.

The Chair (Ms. Ann Hoggarth): Have a great weekend.

Ms. Bonnie Fraser: You too. Safe travels up the 401; the weather is good.

GSK

The Chair (Ms. Ann Hoggarth): Our next presenter: GSK. Good afternoon, sir. Once you get settled, if you could please give your name for the purposes of Hansard, and you may begin your presentation.

Mr. Ryan Lock: Thank you. Good afternoon, everyone. My name is Ryan Lock. I'm the senior manager for external affairs with GlaxoSmithKline Canada. Thank you for welcoming me in here today to speak about an important public health issue, which is shingles prevention for seniors in Ontario.

I believe you all have a copy of the slide deck I'll be aiming to walk through today. I look forward to taking any questions you may have towards the end.

Just a quick disclaimer before we get under way and for the purposes of any questions: I must say that I'm not a doctor or a medical professional. I am trained to speak about the issues we'll be discussing today, but I just want to make sure that we're clear on that point at the outset.

Into the slide deck, on the second page—I suspect many if not all of you are familiar with GSK. We're headquartered in London, England. We operate in over 150 countries worldwide. It's a diversified business with pharmaceuticals, consumer health care and vaccines, and that is in fact what I'm here to speak to about today—vaccines specifically.

On the next slide there's a photo of our manufacturing facility located in Mississauga, at the 407 and Mississauga Road. GSK is very much committed to our manufacturing footprint in Canada, with manufacturing operations both in Sainte-Foy, Quebec, and in Mississauga, where we export over 50 different products.

GSK employs roughly 2,000 employees across Canada, roughly half of which are located here in Ontario. Those employees represent an annual salary injection into the Canadian economy of roughly $170 million.

As it points out on this slide, going back to 2001, we've invested more than $2 billion in research and development in Canada, making GSK one of the top 10 R&D spenders over that period in Canada.

To the next slide: a little bit on our values and ways of working. As a member of Innovative Medicines Canada, we of course subscribe to the IMC industry-wide code of conduct. There are other measures that GSK has taken here in Canada in recent years from a values perspective to enhance that, including, in 2014, moving away from a commission-based sales model to one where we reward our sales representatives based on the quality of the information and education they provide to physicians and health care professionals they meet with.

We're also one of 10 companies that, beginning last year, began voluntarily disclosing transfers of value to physicians and other health care providers. We've been quite public in our support for the government's Bill 160 that aims to shed more light on those transfers of value in Ontario.

On the next slide: In terms of innovation, we have globally, as of the date of this publication, 14 vaccines in

development. I alluded to our research and development investments in Ontario. Many of these vaccines and other medicines are researched here, and patients in Ontario do participate in clinical trials. That was certainly the case with Shingrix, which is the vaccine I'm here to speak with you about today.

On the next slide: Our vaccines portfolio—going from left to right: pediatric, adolescent and adult, and elderly—is the most comprehensive in the industry. To the far right, you'll note that, in October of last year, we received Health Canada approval for a new, innovative herpes zoster shingles vaccine. As I mentioned, it's called Shingrix. It's now available, as of about a week or so ago, in doctors' offices and through pharmacies.

On shingles: It's a very unpleasant condition. On slide 7, you'll see this photo. That's a typical presentation in terms of how shingles presents itself. If you've ever had chicken pox as a youth, let's say, you are at risk for shingles. The same virus that causes chicken pox will remain latent in the body and can re-emerge many years later as our immune systems naturally weaken with age.

One in three Canadians will have shingles at some point in their life. It typically presents itself, as you see here, as a rash, usually on one side of the body or face. The symptoms can last anywhere from weeks to months, in fact.

The best way to deal with shingles, frankly, is to prevent it, because treatment options, once the rash has presented itself, are very limited and largely not as effective as we would like. Prevention is the way to deal with shingles.

Moving to slide 8: This is a chart that shows the annual incidence of shingles in Ontario. Across the country, we would typically see, in a year, about 130,000 cases of shingles—roughly half the population, I guess, of Windsor-Tecumseh. In Ontario, there are roughly 43,000 cases a year.

The next slide: There's a clip here of a news release from the government of Ontario in 2016, where Ontario, as part of the 2016 budget, announced a free immunization program for seniors aged 65 to 70 against shingles. Full credit to the government for making that decision and that investment at the time.

The government, in 2016, went with the only vaccine that was available on the market at that time—it's a competitor vaccine to Shingrix—and that is the vaccine that is still currently used in the publicly funded program.

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When the program was announced in 2016, the Minister of Health was asked, among other questions, why the government chose to limit the availability of the free vaccination program to those aged 65 to 70. As part of his answer—this was Dr. Hoskins—he noted that the profile of the vaccine—again, our competitor's vaccine—suggested that that was the best age group to target based on the characteristics and profile of the vaccine.

On the final slide, our new vaccine, again, approved by Health Canada in October of last year, is approved for the prevention of shingles in those aged 50-plus. In two separate phase III clinical studies, global studies involving tens of thousands of patients, including patients here in Canada, the demonstrated efficacy in the prevention of shingles was above 90%—that was independent of age; ages 50, 60, 70 and 80 were part of the study—versus a placebo.

Fascinatingly, too, efficacy was maintained and continues to be maintained. We have four years of data, four years post-vaccination. A common feature of any vaccine, really, is waning. One would normally expect, particularly in an older adult population, to see the benefits of the vaccine waning over time. Again, with Shingrix, efficacy starting at over 90% has been maintained for four years, based on the data that we have.

As with any vaccine, there are sometimes adverse reactions—you can see those on the page here—the most commonly reported one being pain, redness and swelling at the injection site, mild to moderate pain that will sometimes last a couple of days.

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Ryan Lock: Since the vaccine has been approved for sale in Canada, we have been in discussion with and continue to be in discussion with the Ministry of Health and others across government to explore, in consultation with public health experts and others, opportunities for integrating this innovative new vaccine into Ontario's publicly funded program for shingles, and potentially looking at also expanding the age cohort beyond 65 to 70 for the free vaccination program.

Thank you.

The Chair (Ms. Ann Hoggarth): Thank you, sir. We'll go to the government. MPP Martins.

Mrs. Cristina Martins: Thank you so much, Ryan, for being here. It's great to hear all this clinical trial talk. I worked in pharma for well over 15 years before getting into politics. This is my world. Clinical trials, phase III, double-blind and placebo: That's some of the work I did when I was in pharma. I wanted to thank you for bringing that to me at the end of a very long week.

Thank you also for the work that GSK does. I did not work for GSK, but had many friends who did, and some still do. I know the type of research that is done at GSK not only here in Canada but globally as well, and I wanted to thank you for that.

I appreciate your being here today and the message you're bringing. I know that since the province of Ontario introduced the free shingles vaccine to seniors—about 850,000 seniors who can qualify for the shingles vaccine—we've had to date a couple hundred thousand seniors already taking advantage, if you will, of receiving this publicly funded vaccine.

You attested to the validity of this program and us providing this vaccine free of charge. I see here that Shingrix is now newly approved by Health Canada, just as recently as October 2017. I'm sure that, as you say in the last paragraph of your presentation, you are in active discussions, I imagine, with the Ministry of Health and Long-Term Care. I encourage you to continue doing that. This is obviously a new drug that was not on the market

when we introduced our program and something that I'm sure the minister would be interested to hear about and look over some of the studies, at least, with the national advisory committee to look at that particular drug.

We should be able to provide more access to drugs, and I think that the direction the province took starting January 1 with free medication to those under the age of 25 is a step in the right direction.

I did want to comment on life sciences here in Canada and Ontario being the jurisdiction that employs more than half of that particular sector, and the investments that the province is making to ensure that this sector continues to thrive. As a former member of that sector, I too have a vested interest that it thrives here in the province of Ontario.

Can you tell the committee how investing in the life sciences sector can further contribute to employment in Ontario?

Mr. Ryan Lock: That's an excellent question and one that's certainly near and dear to my heart.

Before joining the industry about two years ago, I was a member of the Ontario public service, and at one point in time in my career I was a director responsible for life sciences policy with the Ontario Ministry of Research and Innovation.

A lot of folks may not know that when we look at the research and scientific assets of Ontario, they rival some of the largest US jurisdictions. There's actually more research intensity in the life sciences in the University Avenue corridor in Toronto than there is in Kendall Square in Boston. So we have tremendous research assets here in Ontario.

Again, GSK continues to invest here largely because of the excellent science. Sometimes we do struggle a little bit as a jurisdiction when it comes to commercialization. GSK is part of industry groups such as Life Sciences Ontario to really make sure that we take a focused look at how we can take that excellent research and commercialize it into even more high-paying jobs both today and into the future.

The Chair (Ms. Ann Hoggarth): One minute.

Mrs. Cristina Martins: One of the things that the province recently did was appoint a chief science officer to advise the government on how to bring more investments to the province, how to continue to support research and innovation. Can you speak a little bit to that and whether that was a step in the right direction?

Mr. Ryan Lock: The Ministry of Research, Innovation and Science, under Minister Moridi's leadership, has been doing some terrific things in recent years, including the appointment of the Chief Scientist. That's a welcome move.

At the Ministry of Health, the appointment of Bill Charnetski—going back a year or so ago—the new chief health innovation strategist, was also a welcome move from the industry's perspective.

Mrs. Cristina Martins: I want to encourage you to continue working with the ministry on the new vaccine that Glaxo just recently received approval for.

Thank you for being here.

Mr. Ryan Lock: Thank you.

The Chair (Ms. Ann Hoggarth): Thanks for your presentation. Have a good weekend.

DR. LAURENE SELLERS

The Chair (Ms. Ann Hoggarth): Our next presenter is by teleconference. Laurene, are you there?

Dr. Laurene Sellers: I'm here.

The Chair (Ms. Ann Hoggarth): Laurene, I'll go around the room and tell you who's at the table here. From the official opposition, we have MPP Bailey and MPP McNaughton. From the third party, we have MPP Gretzky, MPP Vanthof and MPP Natyshak. From the government, we have MPP Martins, MPP Dhillon and MPP Berardinetti.

I'm Ann Hoggarth. I'm the MPP from Barrie and the Chair of the committee.

Please tell us your name and where you're calling from, and then your 10-minute presentation can begin.

Dr. Laurene Sellers: Good afternoon, members of the legislative finance committee. My name is Dr. Laurene Sellers. I'm calling from Grand River Hospital in Kitchener because I'm actually at work today. Thank you so much for listening to me by phone.

I'm a physician with a broad scope of practice, from house calls to hospital and many aspects of medicine in between. I continue to work in the emergency room, and I'm a surgical assistant in the operating room. I've been the president of our local medical staff association of about 500 physicians, and on the board of our two large community hospitals, Grand River and St. Mary's General Hospital in Kitchener. At the provincial level, I have been on the provincial stroke strategy's "Saving the Brain" committee, and I continue to work with Critical Care Services Ontario on the provincial epilepsy task force. That's my background.

Today I'm looking for new funding for team-based health care for the residents of Wilmot township in the region of Waterloo, where I live. I represent the New Hamburg Board of Trade, a community group in Wilmot township. Traditionally, since the 1970s, the New Hamburg Board of Trade has recruited physicians and, when needed, operated the physical facility of the New Hamburg medical clinic. Our business leaders realize how important access to health care is for the community.

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Team-based health care involves health disciplines such as social workers, physiotherapists, registered dietitians, nurse practitioners and doctors, each with a specific scope of practice but the same goal of providing excellent care to patients in the community. Team-based health care provides management of chronic conditions and programs and services for prevention and healthy living. Team-based care is accessible and keeps patients out of the emergency room, which is the most expensive care in the province. Team-based health care provides better care to patients, and health care outcomes are

higher than traditional physician-only care. Both doctors and patients are happier and more satisfied with team-based health care.

Wilmot township is a rural community with a population of about 20,000 people. In Wilmot township, we have three seniors' communities or villages. Seniors in Wilmot are 15.8% of the population, compared to 14% across the province, and I'm sure you know that will only mushroom in the future. We have many new home builds and two new schools in the area. Unfortunately, access to primary care has not kept up with the growth of our community. Thirty-two years ago, when I got married and moved to the community, the population of our township was just about 5,000 people and we had five physicians. Our population has grown to over 20,000 people and we still have five physicians in the township.

A standardized way of looking at accessibility to physicians is number of physicians per 100,000 people. Near Wilmot township are two townships that are similar in demographics, but quite separate in terms of health care and economics. Woolwich township has 46 physicians in primary care per 100,000, and Wellesley township has 44 physicians per 100,000. Wilmot township has less than half of those numbers, with only 19 physicians per 100,000. For reference, please compare that to the twin cities of Kitchener-Waterloo, which have 67 physicians per 100,000. Clearly, our township has a severe deficiency in access to primary care in the community.

One of my current roles, at the large community hospital in Kitchener-Waterloo, is taking care of admitted in-patients. When I look at the demographics of patients in Wilmot township, I notice that many of the family doctors are from Kitchener-Waterloo. Thus, people are driving to the city for care. I also note that many of the physicians have been in the community longer than me, and I have been a physician here for almost 30 years. Many of these physicians are heading for retirement. My proposal of expanding health care in Wilmot township is not like creating empty spaces in the city; with retirement, current health care in the city will be evaporating. For reasons of mobility, local access and our local population, we are looking for health care here at home in the community.

I estimate that, currently, there are about 200 trips per day to the twin cities to seek primary care. This huge carbon footprint can be reduced with access to primary care in the community. No longer can health care be in a silo. We need to think of the environmental impact of health care services. I applaud Telemedicine, Telehealth and Telestroke. These secure video-over-the-Internet technologies provide access to specialists in tertiary care centres, such as downtown Toronto, Hamilton and London for both patients, and Telestroke for physicians. My family members have gratefully accessed these telemedicine services.

On a personal note, I am a parent of a child with disabilities. I realize how many trips we make to the city to seek medical care. As I get older, I want her and other families, as well as seniors, to be able to seek care in our own community. That's part of my motivation. You might ask if I have a conflict of interest as a physician. Am I going to open a family practice for me to set up practice? At this stage in my career of over 30 years in health care, I am not looking to set up a personal family practice.

We do have a local medical school satellite campus of McMaster medical school in Kitchener-Waterloo. The dream of team-based primary care in Wilmot township, which is rural, could provide learning opportunities for learners ranging from medical secretaries to nurse practitioners and physicians. I know how valuable my rural community health experience was when I was a learner years ago. In fact, I continue to work in that group as a locum physician from time to time. My exposure in northern Ontario to the Peninsula Family Health Team has let me see how valuable team-based care can be in the community. I have had the opportunity to see first-hand the transition from physician group medical practice to a family health team. The important care that can be bestowed on people who would fall between the cracks, the community health education and the support to keep people living independently in their homes is truly excellent care for all.

In Wilmot township, community members are supportive of more physicians in the community and team-based health care. As a community, we are working towards planning for expanded medical services. Community members have stepped forward to provide an accessible physical space where our family health care team could be located.

We are asking for $1,699,500 in funding; specifically, $550,000 for compensation for an office manager or executive director, medical secretary, RPN, RN, nurse practitioner and social worker, with benefits being about 20% of that at $110,000. We need $20,000 for information technology; $21,500 for legal and audit; and $50,000 for medical and office supplies. Premises cost—rent and utilities—would probably be about $100,000, and professional development at $48,000. The total of that above would be $899,500, which I believe comes out of the Ministry of Health's budget. The physician cost would be $800,000 for four physicians caring for 6,000 patients, and the nurse practitioners mentioned above would care for some extras.

In summary: Access to health care is important to individuals and the community. Access to primary care compared to other townships locally—both Wellesley and Woolwich, or the province of Ontario—has fallen far behind in Wilmot township. Team-based care is important to our growing community. Our community of Wilmot township asks for your support.

Thank you so much for hearing my presentation today. Does anyone have any questions?

The Chair (Ms. Ann Hoggarth): Thank you, Doctor. The questions will be from the official opposition. MPP McNaughton.

Mr. Monte McNaughton: Thank you very much, Dr. Sellers, for your presentation and for your service to your community.

I just wanted to ask a couple of questions. What are the reasons, in your community and across rural Ontario, that the patient-per-physician ratio has failed to be addressed?

Dr. Laurene Sellers: Thank you for your question. I'm more of a clinician than a politician to be able to answer those questions. I know people prefer to live in communities of cities. It's a rare bird that likes to be a physician in a rural area; I suppose that's part of it. But there are encouraging programs that exist within health care education to bring rural doctors to rural areas. I know the northern Ontario medical school is one of those; it's located in Sudbury and I believe Thunder Bay. Also, there are lots of rural doctors who are trying to encourage residents and medical learners to have exposure to a rural community.

I certainly got the bug when I trained. I continue to work in rural medicine, as well as in the city. By virtue of my family location and my husband's employment, I live in Wilmot township, which is closer to a city, but I love to go to northern Ontario and practise rural medicine as well.

Mr. Monte McNaughton: What are some of the most significant impacts if these ratios are not addressed, in your community, for example?

Dr. Laurene Sellers: I had a woman today in the hospital, and she was older and had shingles all over her face for over a month. Her son was trying to take care of her. She couldn't get the doctor. He could not get her to a doctor, nor were house calls made.

I think with rural medicine we tend to make more house calls. There is more access because we know that patients have trouble. There's a lack of transit. I think if we have an aging community it's really important to have health care close to home so if you need a house call or if you need someone to touch base with you—a neighbour—rural communities tend to keep a really close eye on each other. Health care is just part of that piece.

Mr. Monte McNaughton: Just finally: Has your local LHIN been of assistance in helping you deal with these issues, or as you've been advocating for your issues?

Failure of sound system.

The Chair (Ms. Ann Hoggarth): Hello, Doctor? Are you still there?

Mr. Monte McNaughton: No further questions, thank you.

The Chair (Ms. Ann Hoggarth): Dr. Sellers?

She did say that she was at work, so maybe she had to go. Thank you. If she calls back, we'll do it. There was about a minute and a half left.

WORKFORCE WINDSORESSEX

The Chair (Ms. Ann Hoggarth): All right, we're going to move on to the next presenter: Workforce WindsorEssex. Good afternoon, sir. When you get yourself situated, could you please give your name for the purposes of Hansard and then you may start your presentation.

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Mr. Doug Sartori: Sure, thank you. Good afternoon. My name is Doug Sartori, and I'm here to speak to you as board president and chair of Workforce Windsor-Essex. We're the region's workforce development board.

On behalf of Workforce WindsorEssex's staff and board, we want to begin by praising the government of Ontario for the vision it demonstrated when it launched the local employment planning council pilot in the fall of 2015. Windsor-Essex was fortunate to be one of eight communities chosen to be a part of the pilot, likely in part due to our stubbornly high unemployment and our slow recovery from the global economic downturn.

Our organization provides labour market tools, research and best practices to employers, job seekers, students and educators, and the broader community at no charge. Last week alone, our team visited 19 classrooms to speak to young people about the region's workforce, promising sectors and in-demand jobs. Earlier this week, we launched an experiential learning tool kit for educators and a pair of guides for both educators and parents. This fall, we published a list of the region's top 76 in-demand jobs, as well as a guide for recruiting and retaining your workforce.

In short, your investment is working. We are delivering new labour market tools, research and best practices to the community. Our research tool, for example, helps businesses and job seekers find funding programs and community organizations that can help them, and our transportation and mapping tool overlays job postings and bus routes.

The funding that is working so well for our community should be made available to other communities in the province. My recommendation to this committee is to roll out the local employment planning council pilot to more communities.

The region's number one workforce issue is the issue of people without jobs and jobs without people. We have a disconnect between the supply and demand of talent. School offers students equal opportunity to pursue studies in virtually any field, yet students spend more time planning their prom than their career path. As a province, we graduate too many teachers and not enough skilled trades. To bridge this gap, Ontario may want to:

—roll out age-appropriate, experiential learning initiatives for all grade levels;

—integrate labour market studies into the curriculum;

—find new ways to connect educators and employers;

—fund student transportation to make visiting local workplaces a life-changing experience instead of a once-in-a-lifetime experience;

—provide funding for the development and delivery of innovative, short-term training programs year-round; and

—encourage more women to participate in the workforce, with greater investments in child care, employment supports and training programs.

Workforce WindsorEssex deals with workforce challenges from a regional perspective. This is tremendously

valuable, and by way of example, I'd like to touch on one issue that I think is somewhat under the radar but crucial to Windsor and Essex county: the industry I personally work in, technology, specifically the software industry. Our region has a much smaller ICT sector—ICT means information and communication technology workers. We have a much smaller ICT sector than the Ontario average. Our tech sector workforce is roughly half the size of what you would see in a typical Ontario community. It's a tough situation and it's part of the region's problem of people without jobs and jobs without people. Employers have a difficult time finding skilled people to fill critical technical roles, and it's difficult for a worker to build a successful career in tech. It might not be the most important sector of our regional economy in terms of size or output economically—there are roughly 3,000 people in the region's ICT sector—however, addressing these challenges is crucial for our regional economy overall.

I work as a consultant to industry on technology, and I see this on a daily basis. Our ability to innovate and compete globally is impacted by the limits of our tech sector. The research and data that Workforce WindsorEssex has produced on the tech sector has transformed our understanding of the issue and sparked a long-overdue, serious public conversation about it.

After a decade of stagnation in ICT, Workforce WindsorEssex has established a round table to bring business, workers and educators in the sector together to discuss the challenge and identify solutions. This kind of collaborative regional approach to a problem unique to our part of Ontario is one of the key benefits of our local employment planning council.

The third and final item I wish to touch on today is the importance of the North American Free Trade Agreement. Although your committee may not have a mandate that directly relates to the trilateral renegotiations, all of you are members of provincial Parliament, which is why I think all of you should know just how important this agreement is for the movement of goods, people and ideas across our border.

According to the latest census, 6,795 people living in Windsor-Essex report employment income outside of Canada. Compared to any other border town in Ontario, Windsor-Essex has the most cross-border commuters. Ontarians are caring for Michigan patients, building Michigan goods and solving Michigan problems. Our province and our region's highly educated and talented workforce is critical to the delivery of health care, the production of goods and the business of problem solving for so many American employers. We don't have hard data on the number of visa-holders by type, but our NAFTA survey found that about 80% of respondents cross using a NAFTA visa, which means that if NAFTA ceases to exist so does the employment of 5,000 or 6,000 people in our community. This, in addition to job losses that might arise from the disruption to business supply chains, makes it a critical issue here in Windsor-Essex and for Ontario at large.

That's what I have to say to you today. Thank you for your time.

The Chair (Ms. Ann Hoggarth): Thank you. We'll move to the third party for questioning. MPP Natyshak.

Mr. Taras Natyshak: Thanks, Doug, for being here. Thanks for the work that you do on behalf of Workforce WindsorEssex and for your promotion of our tech sector in coordination with the tech community and those local incubators that are doing such great work trying to develop economic activity in our region. I know it's a challenge because there's a whole lot of competition. Right across that beautiful Detroit River over there is a burgeoning tech sector, as the downtown core of Detroit experiences a renaissance, and so aptly named is the big building you see there, the Renaissance Center. We see Detroit leading the way, unfortunately, in comparison to what Ontario is doing, when it comes to promoting those clusters and supporting development in urban areas.

We've seen an expansion of part-time, precarious work in the province of Ontario, mainly through the use of employment agencies. If I hear a complaint through youth who are looking for good-paying, long-term, stable jobs, it's that: that a lot of employers have had to use and are continuing to use employment agencies to build up their human capital and human resources. Do you have any idea on what the impact is of stability in the workforce as we've seen such a prominence of those agencies in our communities?

Mr. Doug Sartori: I don't have any data on that specific issue, so I'm reluctant to comment in terms of facts. However, I think it's very important, in general terms, that young people in our community can see a stable career and a long-term opportunity for prosperity. I agree with you to the extent that it's very important that precarious work is addressed in Ontario.

Mr. Taras Natyshak: A lot of the work that you do focuses on connecting employers with employees. Where do our post-secondary institutions intersect with that? What role do they play? What can the province do to enhance that connectivity?

Also, I wonder if you can speak to some of those more traditional jobs that aren't in the tech sector—the folks who work in manufacturing, which is the heartbeat of this community, and those infrastructure jobs, like building ICI and commercial and residential buildings. There's a need for people who are skilled in those jobs. I'm sure you're aware of how we support that. What has your experience been with the growth of those employment opportunities?

Mr. Doug Sartori: First, on post-secondary, the University of Windsor and St. Clair College are our major institutions of post-secondary education in our community, and I think both have done significant work to innovate in terms of connecting themselves with employers and connecting students with work opportunities.

I'll just name two programs quickly. The University of Windsor: I have interacted personally with their master's of applied computing program, which puts graduate students out into the community and gives them work opportunities, and also gives them an opportunity to

experience working in Windsor-Essex, which is great because many of our students are not from this region.

1500

For St. Clair College, I can point to their collaboration with Valiant to bring education for the tool and mold sector, and specifically pre-apprenticeships programs, into the institution. I think that they've done excellent work on that.

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Doug Sartori: You mentioned the automotive industry and you mentioned, I believe, construction. One thing I do want to point out about our tech industry is that I think the path forward for both manufacturing and technology in Windsor-Essex is together. It's not likely that Windsor-Essex is going to turn into a Kitchener-Waterloo or a Silicon Valley, so our investment in technology needs to be focused on where we already have economic strength. The three areas I would point to would be manufacturing, for one; logistics, for another; and agribusiness, for the third.

Mr. Taras Natyshak: You referenced, in the literature, experiential learning. Our colleague Peggy Sattler has been promoting work-integrated learning. We're talking about the same thing here, right? It's connecting your academic endeavours to a job at the end of the line.

The Chair (Ms. Ann Hoggarth): Thank you.

Thank you, Mr. Sartori.

Mr. Doug Sartori: Thank you.

DR. LAURENE SELLERS

The Chair (Ms. Ann Hoggarth): At this point, committee, we have Dr. Sellers back on the phone. She is anxious to answer MPP McNaughton's last question.

Dr. Sellers, are you there?

Dr. Laurene Sellers: I'm here. It's Dr. Laurene Sellers.

The Chair (Ms. Ann Hoggarth): Okay.

Dr. Laurene Sellers: I believe the question from MPP McNaughton was, basically, why I didn't approach our local LHIN. It's an awkward question.

In the fall of 2017, I initially started my quest by approaching the Waterloo Wellington LHIN. I was told by the person responsible for primary care, Gloria Cardoso, that lack of service and access in the Wilmot township was on the radar screen at the LHIN. She was planning to have a meeting and bring interested parties together. The meeting did not happen. Ms. Cardoso is no longer with the LHIN.

When I approached the LHIN earlier this year to find out where we were at, I was directed to Sarah Farwell, who told me that the meeting would not be organized by the LHIN. I understood her to say that we could sort it out locally in the township.

Thus, I'm asking, for the provincial budget, that the economic and finance committee recommend that we have funding for a family health team in rural Wilmot township, which is grossly underserviced at this point.

Thank you.

The Chair (Ms. Ann Hoggarth): Thank you very much.

MPP McNaughton, do you have another question?

Mr. Monte McNaughton: Thank you very much, Dr. Sellers. That's all I had.

Dr. Laurene Sellers: Okay. Safe home, everyone.

CLASS 1 INC.

The Chair (Ms. Ann Hoggarth): I call our final presenter of the day, Class 1 Inc. Good afternoon, sir. When you get settled, please give your name for the purposes of Hansard, and you may begin your presentation.

Mr. Barry Hunt: Wonderful. My name is Barry Hunt. Thank you very much for adding me to your agenda for today. I'm from Kitchener-Waterloo, and my company is in Cambridge. I made the four-hour trip down here today, with a one-hour delay in traffic, to see you. Anyway, I appreciate the opportunity to speak today.

I've been involved in the health care industry for years and years. I wanted to be a doctor when I was young; I wanted to be a doctor-inventor. For the last 37 years, I've been inventing things for health care, working for hospitals and working in industries supplying to hospitals etc.

I presented to this committee last year at Queen's Park and made a written submission the year before. I'm back here for the third time to basically speak about the same subject. I've added a few words, the word "crisis" in particular, to address this issue, which is the health-care-acquired infection crisis.

It seems to me that things seem to get funded when we put the word "crisis" behind them. We have the opioid crisis, and we have the hospital wait-time crisis and the overcrowding crisis, so I'm going to call it a crisis because it is, in fact, a crisis.

I'm here to represent my company, which has a vested interest in this, but I'm also here to represent a not-for-profit coalition I started called CHAIR, the Coalition for Healthcare Acquired Infection Reduction. We work with the University of Waterloo, infectious disease doctors etc. across the country and internationally.

Patients here in Ontario—this week, we'll have 2,000 patients in hospital who should not be there. They should have been discharged last week, but they're there this week because they have hospital-acquired infections. So now they're not there for one week; now they're there for two weeks. About 100 of those patients, especially because we're in this particular season, are not going to make it to see next week. That is a crisis.

We're spending $54 billion a year on health care here in Ontario. I'm asking you to spend $54.1 billion, to address this crisis.

I've got a written submission here—it's about six pages—and a letter I typed up last night. Then there are a number of slides in there as well that you can follow along. Feel free to ask me any questions at any time today or as a follow-up.

I'll read through, or skip through, some of this letter here now.

Essentially, if we invest in engineered infection prevention, where we put technology into our hospitals now to eliminate air, water and surface transmission of disease in our hospitals, we could save about a billion dollars a year, and we could let those 2,000 people go home, or at least 1,500 of them. That's the general pitch.

Here in Ontario, over the last 50 years, we built hospitals that put two or four people in a room, so they're sharing the same air, they're sharing the same bathrooms and they're sharing the same diseases. We have the dubious honour of having the highest infection rate in hospitals of any developed country, and in the country, Ontario is second to none, of the provinces.

Most developed countries have single-patient rooms. We've only started building hospitals with single-patient rooms now, and even our commitment there—the national standard says 100% single-patient rooms. In Ontario, we're only doing 80%. BC has committed to 100%; Quebec has committed to 100%. We've gone 80% of the way there, to commit to 80% single-patient rooms. That cuts our infection rates in half.

When we've got four people in a room, sharing diseases, we have a 1-in-10 chance of catching an infection when we go there. So if you have 200 people who go into a hospital in a particular week, of those 200 people, 20 of them are going to get an infection. They might have gone in for a knee or an ankle or who knows what, but they're going to get an infection. Of those 20 who get an infection, one is going to die. So that is a crisis, in my opinion.

This is a problem across the world, but it's worst here in Ontario. So we have worked really hard with a lot of different companies and universities to develop technology to overcome this deficit.

Hospital-acquired infections, or HAIs, are the leading cause of preventable death here in Ontario, in Canada and in the developed world. They're the third leading cause of death in Canada. Heart and stroke are number 1; cancer is number 2. The hospital itself is number 3, and that's what we would like to change.

In Ontario, we have the sickest patients, we have the most overcrowding and we have the highest infection rates. To me, that's the number one crisis in health care.

Yes, wait times are high; yes, we have overcrowding; but that's just contributing to the problem. It's a vicious cycle, actually, because infections are a major contributor to that problem that we have.

This year, 76,000 people here in Ontario will get an infection from the hospital they go to for treatment, and close to 4,000 will die.

Infections are expensive: an average of $20,000 per case, and $38,000 per C. difficile case. Direct treatment costs here in Ontario are over $2 billion, out of our $54-billion budget, each year. If you look at the overall impact to the economy, with the impact on families, it's significantly higher.

The domino effect is very significant. If you've got 2,000 people in hospital who shouldn't be there, 2,000 people can't get in. It backs up the ERs, and we have our overcrowding situation. Right now, most urban hospitals here in Ontario, despite adding 1,235 surge beds, have significant overcrowding. We have 40% above occupancy in most hospitals in urban centres in Ontario right now.

The new hospitals we're building all have single-patient rooms, or 80% single-patient rooms, but it's going to take 30 years and $50 billion to add the hospital rooms that we need to cut our infection rate in half, which is why I'm suggesting that we use technology to do that job, because we can roll that out right away.

This group of technologies that we worked with a number of different groups to develop—it won a top 10 world patient safety innovation award last year. This is a global initiative. It's a spinoff of the Clinton Global Initiative. Bill Clinton was there; Joseph Biden was there; a lot of bigwigs from around the world were there. It's a top-10 innovation in the world, building technology into your hospitals that eliminate this stuff—eliminate it in the air, eliminate it on surfaces, and eliminate it in the water.

1510

We use things like copper surfaces that can disinfect; as the snowflakes of bacteria and viruses land on the surface, they melt. We have UV flashing lights that can self-disinfect patient rooms, that can self-disinfect patient bathrooms etc. We've been rolling it out in hospitals across the country and down in the US. It's being studied; it's got proven results.

We have the worst problem here. It's been developed primarily here in Ontario. We need to start rolling out this technology.

I've been around health care for 37 years and I have seen how long it takes to roll out any new technology. We were late to the game with CAT scans, MRIs, PET scans, dialysis etc. I've watched it take 15 to 20 years behind what they're doing in the US right now. Right now, the US has a moon shot going on; we don't have that equivalent moon shot going on yet. We need specific funding to get that going.

Hospitals right now, because they're strapped for cash all the time, are not interested in investing in new technologies, new infrastructure or new capital equipment to address any problems. They're not even acknowledging that there is a crisis in this situation in the first place. If you were to look at a death certificate for somebody now, it's very rare that you will see C. difficile or MRSA. They might have gone in for cancer as their primary diagnosis, picked something up and died of C. difficile, but it will still say "cancer" on their death certificate. In the newspaper, in the obituary, it will still say "cancer." We need to correct that situation, but for now, even without the accurate numbers for the province, we can see that it's a major problem.

Most people know someone who has had a problem. Even if you don't die from your disease, a lot of people

are changed forever by that disease. Of the 20 people out of 200 who go in and get infected, one dies and 19 are survivors. Of the 19, half may be changed forever. They may have intestinal problems forever with C. difficile. It's a major, major issue.

Seventeen years is what it generally takes in health care for a new technology to get implemented. That's because you have to sell it to so many different people on the way up because there's no budget for it etc. We need a top-down moon shot this time, a line-item budget that says that we're going to address this.

The UK has taken this type of approach for their projects—

The Chair (Ms. Ann Hoggarth): One minute.

Mr. Barry Hunt: —and it's worked quite well. In the US, they've taken a similar approach. They've dropped their infections by 21% in the last five years. Ours continue to go up. We can't wait that 17 years.

We invested $140 million in home care and temporary beds for the flu this year. We committed $222 million to handle the opioid crisis, with 865 deaths per year. We're talking almost five times that rate. We need to put $100 million a year into it, and $54 billion to $54.1 billion to address this issue forever.

I'll yield my time for questions.

The Chair (Ms. Ann Hoggarth): Okay. We go to the government. MPP Potts.

Mr. Arthur Potts: Thank you, Mr. Hunt. That was exhilarating. You have the distinction of being our last deputant in five days of hearings across the province this week, and I just want to tell you, that was uplifting. The enthusiasm you show as an entrepreneur and as an inventor, I identify with. I'm very impressed with your presentation, particularly your persistence. You talked about how it's the third time you're here. That is one of the most important criteria for a successful entrepreneur, that persistence, to keep pushing at it. This is the third kick at the can. I'm hoping we can see some results from it.

You're absolutely right: One of the reasons you may not see this happen is because it has created a fear of going to hospitals. I know I see it in my own family. My mother is 89 and had some issues over the holidays, and it was, "Don't take her to the hospital. Let's go to clinics, let's do this," because of that fear; she's somewhat feeble. What you have here is a solution-driven approach which I hope we can find a way to address.

We also see the crisis in adverse drug reactions. I know of other people who are trying to get into the system that way, and it's the same issue because it requires new technology to address this crisis.

You talked about how you've met with Dr. Hoskins. He's toured your facility. Where are your discussions with the ministry now?

Mr. Barry Hunt: During his visit—that was two years ago—he was very positive. He expressed a lot of interest in it. I said, "Great. Let's fund it." He said, "Well, it's not that simple. There's a process." I understand that.

The Ministry of Health and Long-Term Care capital equipment branch, which looks after building hospitals and designing hospitals, is putting this technology into new builds now wherever you have shared bathrooms and shared patient rooms, wherever you have high-risk situations—stem cell transplant, bone marrow transplant, things like that. But it's very limited and it will be a 30-year rollout at that pace, when the real problem is in the existing facilities that could be transformed very, very quickly and very efficiently.

Mr. Arthur Potts: We're building a whole new hospital wing in my community, at Michael Garron Hospital. I'm assuming that the developer is embracing the latest technologies. You're right. Most of them are going to be single-patient rooms, and that's part of it, because we have eight-patient ward rooms now that are coming out.

It's an interesting hospital because it's very entrepreneurial. They were concerned about low-flow toilets. There was a direction to save water for the environment. One of the nurses was looking and said, "I'm getting a sense that these are splashing." So she threw some coloured dye in—it was ultraviolet—flushed it and noticed that they were splashing everywhere. So they redeveloped the toilet in order to make a low-flow toilet that doesn't splash, in order to control infections. But you've taken this to a whole new level.

Mr. Barry Hunt: A whole new level; completely eliminates it.

Mr. Arthur Potts: Yes, I'm absolutely thrilled by it. Now is it more important—you talked about the old facilities having the highest impact right now in order to start to address this issue.

Mr. Barry Hunt: On any given day, 99% of your infrastructure is existing. So, yes, it will have the greatest impact.

Mr. Arthur Potts: So on new builds, it's not as big an issue?

Mr. Barry Hunt: New builds already have a 50% lower threshold, but that means they still have 50% left to go, and 90% of that remaining 50% can be addressed with technology.

Humber River Hospital, Canada's first all-digital hospital—a beautiful facility with single-patient rooms—redeveloped the old Finch site of Humber for the re-activation centre for the flu beds. They have two patients in a room. So they put the technology into the old facility, but they wished they had it in their new facility because they still—even though the rates are half—have a problem.

Mr. Arthur Potts: I see a very impressive return on investment. You identified some of the numbers here today, but in terms of the health outcomes, this almost seems like a no-brainer. Do you have competition? Is this a place where we need to be putting tenders out and then you have to win competitions?

Mr. Barry Hunt: Most of the technology is patented and innovative and new and exclusive. For some of the technologies—for example, coatings of copper sur-

faces—there would be a number of different companies that could do that. But some of the smart, intelligent AI technology with flashing UV etc., that is all protected.

Mr. Arthur Potts: What are your barriers to getting into the system?

Mr. Barry Hunt: Bottom up, to hospitals that don't have a budget from the Ministry of Health to—

Mr. Arthur Potts: I hope I can introduce you to the builders of our new hospital. I hope that this is in my community.

Mr. Barry Hunt: I would love to.

Mr. Arthur Potts: Fine; we'll talk afterwards.

Mr. Barry Hunt: Okay, thanks.

The Chair (Ms. Ann Hoggarth): That's all the questions from the government?

Mr. Arthur Potts: That's all.

The Chair (Ms. Ann Hoggarth): Thank you very much for your presentation, and have a good weekend.

Committee members, we are now adjourned until 9 a.m. on Wednesday, January 31, when we will meet for the purpose of report-writing at Queen's Park.

The committee adjourned at 1518.

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